DOCUMENT RESUME

ED 301 117 HE 021 985

TITLE	Nurse Shortages. Hearing before the Subcommittee on Health of the Committee on Finance. United States Senate, One Hundredth Congress, First Session.
INSTITUTION	Congress of the U.S., Washington, D.C. Senate Committee on Finance.
REPORT NO	Senate-Hrg-100-530
PUB DATE	30 Oct 87
NOTE	138p.; Some pages contain small print.
AVAILABLE FROM	Superintendent of Documents, Congressional Sales Office, U.S. Government Printing Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	Educational Legislation; Federal Legislation; Health Personnel; *Health Services; Hearings; Higher Education; *Nurses; Nursing Education; Policy Formation; *Public Policy
IDENTIFIERS	Congress 100th; *Nursing Shortage

ABSTRACT

The Subcommittee on Health of the Committee on Finance of the United States Senate met to examine the U.S. nursing shortage crisis which is adversely affecting the health care of all Americans, but particularly the elderly who consume a disproportionate share of health care services. It was intended to solicit views and recommendations from interested groups on ways to address this crisis, including possible changes in the medicare teaching adjustment to hospitals. Opening statements were heard from Senators George J. Mitchell, David Durenburger, John D. Rockefeller IV, and John H. Chafee. Public witnesses include the following people: Barbara Curtis, American Nurses' Association, Inc.; Jan Towers, American Academy of Nurse Practitioners; Christine Zambricki, Mount Carmel Hospital, Detroit, Michigan; Charles D. Jenkins, Union Memorial Hospital, Baltimore, Maryland; Margaret J. Cushman, the VNA Group, Inc., Waterbury/Hartford, Connecticut; Paul R. Willging, American Health Care Association; Nancy P. Greenleaf, University of Southern Maine, School of Nursing; and Nelville E. Strumpf, Gerontological Nurse Clinician Program, University of Pennsylvania School of Nursing. (SM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

BEST COPY AVAILABLE

ED301117

S. HRG. 100-530

NURSE SHORTAGES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

OCTOBER 30, 1987

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

HE 021 • 985

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

83-151 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

COMMITTEE ON FINANCE

LLOYD BENTSEN, Texas, *Chairman*

SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, JR., Michigan
JOHN D. ROCKEFELLER IV, West Virginia
TOM DASCHLE, South Dakota

BOB PACKWOOD, Oregon
BOB DOLE, Kansas
WILLIAM V. ROTH, JR., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOLM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado

WILLIAM J. WILKINS, *Staff Director and Chief Counsel*
MARY MCAULIFFE, *Minority Chief of Staff*

SUBCOMMITTEE ON HEALTH

GEORGE J. MITCHELL, Maine, *Chairman*

LLOYD BENTSEN, Texas
MAX BAUCUS, Montana
BILL BRADLEY, New Jersey
DAVID PRYOR, Arkansas
DONALD W. RIEGLE, JR., Michigan
JOHN D. ROCKEFELLER IV, West Virginia

DAVID DURENBERGER, Minnesota
BOB PACKWOOD, Oregon
BOB DOLE, Kansas
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania

C O N T E N T S

OPENING STATEMENTS

	Page
Mitchell, Hon. George J., U.S. Senator from Maine, Chairman, Subcommittee on Health	1
Durenburger, Hon. David, U.S. Senator from Minnesota	11
Rockefeller, Hon. John D. IV, U.S. Senator from West Virginia	22
Chafee, Hon. John H., U.S. Senator from Rhode Island	25

COMMITTEE PRESS RELEASE

Nurse Shortages	1

PUBLIC WITNESSES

Curtis, Barbara, RN, Member, Board of Directors, American Nurses' Association, Inc., Chicago, IL, accompanied by Thomas P. Nickels, Director, Congressional and Agency Relations, American Nurses Association, Inc.	3
Towers, Jan, PH.D., CRNP, Past President and Legislative Chairman, American Academy of Nurse Practitioners, Grantham, PA	5
Zambricki, Christine, CRNA, BSN, MS, Director of Nurse Anesthesiology, Mount Carmel Hospital, testifying on behalf of the American Association of Nurse Anesthetists, Detroit, MI	7
Jenkins, Charles D., President, Union Memorial Hospital, Baltimore, MD, accompanied by Margaret L. McClure, RN, ED.D, Executive Director of Nursing, New York University Medical Center and Past President, American Organization of Nurse Executives, New York, NY, testifying on behalf of the American Hospital Association	13
Cushman, Margaret J., RN, MSN, President and Executive Director, the VNA Group, Inc., testifying on behalf of the National Association for Home Care, Waterbury/Hartford, CT	15
Willging, Paul R., PH.D., Executive Vice President, American Health Care Association, Washington, DC	17
Greenleaf, Nancy P., RN, DNSC, Dean, University of Southern Maine, School of Nursing, testifying on behalf of the American Association of Colleges of Nursing, Portland, ME	25
Strumpf, Neville E., RN, PH.D., Assistant Professor and Director, Gerontological Nurse Clinician Program, University of Pennsylvania School of Nursing, testifying on behalf of the National League for Nursing, Philadelphia, PA	28

IV

APPENDIX

Alphabetical Listing and Material Submitted

	Page
Chafee, Hon. John H.:	
Opening statement	25
Prepared statement	32
Curtis, Barbara:	
Testimony	3
Prepared statement	39
Cushman, Margaret J.:	
Testimony	15
Prepared statement	33
Durenberger, Hon. David:	
Opening statement	11
Prepared statement	46
Special report, the Nurse Shortage, Myth or Reality?, from the New England Journal of Medicine, Sept. 3, 1987	47
Health Policy Report, Problems Facing the Nursing Porfession, by John K. Iglehart, from the New England Journal of Medicine, Sept. 3, 1987	52
Greenleaf, Nancy P.:	
Testimony	25
Prepared statement	88
Heinz, Hon. John:	
Prepared statement	58
Jenkins, Charles D.:	
Testimony	13
Prepared statement	60
McClure, Margaret:	
Testimony	14
Mitchell, Hon. George J.:	
Opening statement	1
Prepared statement	67
Rockefeller, Hon. John D. IV:	
Opening statement	22
Prepared statement	70
Strumpf, Neville:	
Testimony	28
Prepared statement	71
Towers, Jan:	
Testimony	5
Prepared statement	79
Willging, Paul R.:	
Testimony	17
Prepared statement	82
Zambricki, Christine:	
Testimony	7
Prepared statement	94
Letter to Senator Mitchell	101

Communications

	Page
American Association of Critical-Care Nurses	103
Judith A. Belliard, R.N. and Amelie Gladman, R.N., letter to Senator Mitchell	111
Drake University	112
Geisinger Foundation	114
Hospital Association of Pennsylvania	118
Donalda Dunnett, RN and Gary Peichoto, RN, M.S., Staff Nurses in Cardiovascular Intensive Care, Stanford University Hospital	122
Determining Cost of Direct Nursing Care by DRGs, by Malinda Mitchell, Joyce Miller, Lois Welches & Duane D. Walker, from Nursing Management, April 1984	125
A. Yvonne Gorecki, RN, MPH, MA, Administrative Director, Patient Care Services, St. Joseph's Hospital & Health Center, letter to Senator Mitchell	129
Claire M. Fagin, Dean and Professor, University of Pennsylvania, letter to Senator Mitchell	130
Colleen Conway-Welch, PhD, CNM, FAAN, Professor and Dean, School of Nursing, Vanderbilt University, letter to Senator Mitchell	131

NURSE SHORTAGES

FRIDAY, OCTOBER 30, 1987

U.S. SENATE,
SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m. in Room SD-215, Dirksen Senate Office Building, Hon. George J. Mitchell, chairman, presiding.

Present: Senators Mitchell, Rockefeller, Chafee and Durenberger.

The prepared statements submitted by Senators appear in the appendix.]

[The press release announcing the hearing follows:]

[Press release No. H-66, October 16, 1987]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON NURSE SHORTAGES

Washington, DC.—Senator George Mitchell (D., Maine), Chairman of the Senate Finance Subcommittee on Health, announced today that the subcommittee will hold a hearing to examine the current nursing shortage crisis which is adversely affecting the health care of all Americans, but in particular, the elderly who consume a disproportionate share of health care services.

The hearing is scheduled for Friday, October 30, 1987 at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.

"The hearing is intended to solicit views and recommendations from interested groups on ways to address this crisis, including possible changes in the medicare teaching adjustment to hospitals," Mitchell said.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, U.S. SENATOR FROM MAINE, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Senator MITCHELL. Good morning, ladies and gentlemen. The hearing will come to order.

We are here today to examine the shortage of nurses in our nation's hospitals, nursing homes, and home care agencies. We will examine the causes of the shortage and look for possible solutions to this problem, which affects the health care of all Americans but in particular the elderly, who most rely upon health care.

Since the days of Florence Nightingale when women had few career options outside of marriage, nursing has been considered an honorable and leading profession for women. But women's lives and options have changed dramatically since the nineteenth century. According to a recent survey by the Higher Education Research Institute at the University of California at Los Angeles, for the first time in our nation's history there are more freshman women in four-year institutions aiming for careers as doctors than as nurses. While this is a testament to increased opportunity and equality for women in our society, it has had a negative effect upon

the need to continue to provide an adequate supply of nurses in the nation's hospitals, nursing homes, and other health care facilities.

As our population ages, the need for nursing care increases, especially the need for nurses with specialized training and competency in geriatrics and rehabilitation.

Unfortunately, the supply of nurses and enrollment in schools of nursing is declining. According to the latest federal projections, by 1990 demand for baccalaureate prepared registered nurses will exceed the supply by about 390,000. By the year 2000, the gap is expected to grow to more than one million.

In recent months we have heard of a shortage of nurses here in the District of Columbia which created a serious problem for one of the local hospitals. This problem is widespread and affects institutions across the country in both urban and rural areas. The Maine Medical Center, the largest and most comprehensive hospital in my State, with an occupancy rate of over 95 percent, has been forced to eliminate the use of 10 beds because they cannot find the nurses to staff them.

The reasons for the current situation are complex; the solutions will, therefore, not be simple or easy. We must examine the causes of the problem and work together to develop reasonable solutions to the problem.

Earlier this year I joined with Senator Kennedy and others in sponsoring legislation intended to establish programs to reduce the shortage of professional nurses. That bill, The Nursing Shortage Reduction Act of 1987, passed the Senate on August 5th and is awaiting action in the House. I am hopeful that it will be enacted into law before the end of this year.

On October 7th I introduced the Nursing Manpower Shortage Act, which would provide payment for direct graduate medical costs related to nurse clinical training through the Medicare Program.

These bills attempt to address the nursing shortage, each in a different way. Senator Kennedy's bill is intended to address the registered nurse staff nurse shortage, while mine is intended to provide a career track for the graduate level nurse.

One of the reasons often cited for nurses leaving the profession is the lack of career advancement after the first few years. While the entry-level registered nurse makes a reasonable salary, within five to seven years she has frequently peaked in terms of income and responsibility. My bill would create incentives for nurses to go on beyond the baccalaureate level to pursue careers as nurse practitioners, nurse midwives, and masters and doctoral level nurses.

I look forward to working with all interested parties and groups in reviewing and improving the provisions of the Nursing Manpower Shortage Act. I hope this hearing will be the beginning of a constructive dialogue between the health care community and Congress in finding workable solutions to the nursing shortage problem which threatens the health care of all Americans.

We have a distinguished series of witnesses today, consisting of three panels. The first panel includes—and I ask them to come forward as I call their names—Barbara Curtis, a Registered Nurse, member of the Board of Directors of the American Nurses Association; Jan Towers, Ph.D., Past President and Legislative Chairman

of the American Academy of Nurse Practitioners; and Christine Zambricki, Director of Nurse Anesthesiology at Mount Carmel Hospital, of Detroit, testifying on behalf of the American Association of Nurse Anesthetists.

Good morning and welcome. We look forward to your testimony. For those of you not familiar with the rules of the Committee, let me state them for the benefit of these and subsequent witnesses. Your written testimony will be placed in its entirety in the record for review by members of the committee. In order to permit all witnesses to have an opportunity to testify and to give ample opportunity to questions from members of the subcommittee, we ask that you limit your oral remarks to five minutes, that you use that to hit what you believe are the highlights of your statement. To assist you, we have a panel of lights here. They mean the same thing as traffic lights: the green light means keep going, the orange light means your time is coming to a halt, and the red light means stop.

We look forward to hearing from you, and we will begin with the witnesses in the order they are listed. Ms. Curtis, welcome.

STATEMENT OF BARBARA CURTIS, RN, MEMBER, BOARD OF DIRECTORS, AMERICAN NURSES' ASSOCIATION, INC., CHICAGO, IL, ACCOMPANIED BY THOMAS P. NICKELS, DIRECTOR, CONGRESSIONAL AND AGENCY RELATIONS, AMERICAN NURSES' ASSOCIATION, INC.

Ms. CURTIS. Thank you.

Good morning, Mr. Chairman. I am Barbara Tolman Curtis, a member of the Board of Directors of the American Nurses' Association. I am pleased to appear today on behalf of our 188,000 members to discuss, obviously, an issue of overriding concern, that of the nursing shortage. Accompanying me today is Tom Nickels, ANA's Director of Congressional Relations.

As the largest organization of registered nurses in this country, we appreciate the attention that this committee has given to the subject of the nursing shortage.

The publicity surrounding the nursing shortage has been overwhelming because communities across the country are reporting an ever-increasing shortage of nurses, and the outlook, unfortunately, for the future is very bleak.

For example, a December 1986 study conducted by the American Hospital Association revealed that 13.6 percent of hospitals' registered nurse population jobs were vacant in 1986. This compared to only 6.3 percent in 1985. Two-thirds of the hospitals reported that they actually need more than 60 days to fill a vacancy.

The nursing shortage stems from a variety of factors, including modest financial rewards compared with nurses' responsibilities, limited authority for the clinical practice of nursing, and little involvement in management decisionmaking.

While there are numerous reasons for the nursing shortage, two major causes really seem to be at the root of the problem, and those two are salary and working conditions.

With respect to salary, it is not the starting salary, as Senator Mitchell mentioned, in hospitals that causes the problem. Salaries are actually not commensurate with experience and responsibility;

so that a nurse, when they have 10 years of experience, will not see his or her salary increase or reach much beyond the $30,000 level. Compared with the income received by other health care professionals, nurses are seriously underpaid and undervalued as employees. Salaries for nurses must be commensurate with their level of responsibility, education, experience, as well as performance. Without such recognition, the nursing crisis will continue and be exacerbated.

Regrettably, there is little that the Federal Government can actually do directly about nursing salaries. The Prospective Payment System, in which hospitals are paid a lump sum for care, doesn't lend itself to changes that would increase pay to employees. However, Congress should begin to put pressure on hospital administrators to raise those salaries. Hospitals and other institutions must realize that a major solution to the shortage problem is to pay a more realistic salary to their nurse employees.

The second major cause of the nursing shortage involves the environment in which nurses work. Working conditions are really quite difficult, with nurses often being treated poorly. Nursing should be involved in policy development and decisionmaking throughout the organization, and that rarely occurs at present.

Studies have shown that effective nursing practices are found where conditions of employment foster professional growth and development. Again, the solution to enhancing the work environment for nurses does not lie entirely with the Federal Government. We ask that perhaps the committee could send a clear message to the hospital and nursing home industries that such a change is essential and that failure to enhance salaries and working conditions may need to be met by congressional action, such as the promise of increased regulation.

While we have focused on hospitals, it is important to note that the situation is far different in nursing homes. Salaries are actually 15 to 25 percent below those in hospitals, and working conditions are more difficult even.

The nursing home industry has really refused to provide adequate compensation for their employees and has fought against minimum staffing requirements. In our view, the shortage in nursing homes can be lessened by mandating increased nurse staffing. Only when forced by the Federal Government will nursing homes hire adequate staff. Such a requirement will force the industry to pay a competitive wage in order to attract the required personnel.

Therefore, we commend the Chairman for his efforts to increase RN staffing in nursing homes through the inclusion and reconciliation of his legislation S. 1108. However, we ask that in conference the committee might accept the House Energy and Commerce Committee provision, which requires an RN for 16 hours per day in facilities of 90 beds or more, and eight hours in facilities of 90 beds or less.

We would also like to commend the Chairman for his introduction of S. 1765. We are particularly pleased with the establishment of a demonstration authority for community nursing organizations. By allowing nurses to establish these organizations and receive payment for their services, which they do not receive under cur-

rent law, we believe the number of nurses willing to remain in the profession will greatly increase.

Section three of the bill will allow nurse practitioners and clinical nurse specialists to certify and recertify patients in nursing homes. As geriatrics is a major area of the shortage, this provision would make far more attractive the nursing practice in nursing homes. Allowing nurses to certify the need for care, and paying them for that service, will provide nurses with another attractive career option.

Section one of S. 1765 envisions the expansion of graduate medical education pass-through.

We appreciate the opportunity to discuss these issues and hope that this hearing will help focus the continued need and concern and attention on the issue.

Thank you very much.

[The prepared statement of Ms. Curtis appears in the appendix.]

Senator MITCHELL. Thank you, Ms. Curtis.

Dr. Towers, welcome. We look forward to hearing from you.

STATEMENT OF JAN TOWERS, PH.D., CRNP, PAST PRESIDENT AND LEGISLATIVE CHAIRMAN, AMERICAN ACADEMY OF NURSE PRACTITIONERS, GRANTHAM, PA

Dr. TOWERS. In addition to the information on the witness list, I am a practicing Nurse Practitioner. I serve in a rural underserved population. I serve as a clinician in the Adams County Migrant Health Program in Central Pennsylvania.

I am here today to express the concerns of the American Academy of Nurse Practitioners regarding the current nursing shortage in our country. At a time when a diversity of service-oriented occupations are available to young people graduating from our secondary schools, the need to make the profession of nursing an attractive and desirable occupational choice is extremely important.

This situation becomes particularly acute when one considers also the increased need for nurses to provide services for patients in the increasingly diversified health care systems in our country.

A particular problem arises in areas of health care requiring the utilization of nurses in advanced practice, for which the shortages of nurses in our communities comes a reduction in the potential pool for nurses entering programs to prepare them for advanced practice. The arrival of this shortage, when the demand for specialists such as Nurse Practitioners is increasing significantly across the nation, makes the situation particularly acute. The need for attention to the alleviation of the nursing shortage through the support of innovative nursing education and nursing service activities is now, when consumers expect more and better care for their health care dollars.

Unfortunately, this shortage will have its major impact in the provision of care to the underserved populations in our country. Yet, it is in the economy's best interest for Congress to attune itself to methods for providing quality cost effective care for these people. One of these methods is to assure the preparation and remuneration of cost effective providers of health care for these populations—nurses.

For this reason, we would call your attention to the need for funding, first to assure quality basic education for nurses, but also to prepare nurses at the graduate level to undertake nursing roles for which there is an increasing demand in all segments of the population, and particularly among women, children, and the elderly.

In a report from the Congressional Budget Office as early as 1979, a summarization of findings of numerous studies focusing on Nurse Practitioners demonstrated that Nurse Practitioners have performed safely and with high levels of patient satisfaction. Nearly 10 years later, the December 1986 report of the Office of Technology Assessments presents a similar report. In that report, patients not only rated themselves highly satisfied with the care they received from Nurse Practitioners but also gave particularly high scores in the areas of personal interest exhibited to the patient, reduction of the professional mystique of health-care delivery, amount of information conveyed, and cost of care.

Some of the innovations initiated in the 100th Congress to provide funds for graduate nursing education are needed at this time in order to recruit individuals to enter specialist roles in nursing. Without such funding, many qualified candidates may be unable to embark on careers in nursing or programs in advanced practice. Incentives and assistance are needed.

Not only is legislation for funding educational and nursing service programs needed, but additional legislation which will allow nurses such as Nurse Practitioners to function more efficiently and effectively must be passed.

We support bills such as Senate Bill 1765, which would provide for Medicare reimbursement for Nurse Practitioners, contracting with long-term care facilities to certify for Medicare eligibility, and would provide for the establishment of nurse-managed community health care centers. These provisions are badly needed.

The absence of legislation enabling Nurse Practitioners to receive payment for practice, particularly among the underserved populations, serves as a potential deterrent to the Nurse Practitioner's willingness to stay in these settings. Such enabling legislation motivates and enables a nurse to enter a field of health care which, aside from these restraints, is rewarding and productive, especially from the consumers' point of view. The biggest reward a Nurse Practitioner obtains comes when a serious illness is prevented in a child, when a woman or man understands the mechanisms for preventing Aids, or an elderly patient's hypertension and diabetes is managed in such a way that that individual is a comfortable and productive member of the community.

The need for legislation to enable Nurse Practitioners to serve this population, particularly in the areas of Medicare and Medicaid, is sorely needed and long overdue. Not having to overcome these funding or reimbursement obstacles would go a long way toward reducing consumer and Nurse Practitioner frustration. It would, instead, facilitate the provision of documented quality of health care through more efficient use of the skills of all Nurse Practitioners, regardless of their specialties—Family, Adult, Pediatric, Obstetric/Gynecologic, Geriatric.

In conclusion, we would ask that the Senate seriously consider the need for additional funding for recruitment and preparation of

nurses for basic and advanced practice roles, particularly among undeserved populations. In addition, we would ask for serious consideration of the need for legislation which enables all Nurse Practitioners to be reimbursed for the services they are providing, particularly Medicare and Medicaid.

[The prepared statement of Dr. Towers appears in the appendix.]

Senator MITCHELL. Thank you very much, Dr. Towers.

Ms. Zambricki, welcome.

STATEMENT OF CHRISTINE ZAMBRICKI, CRNA, BSN, MS, DIRECTOR OF NURSE ANESTHESIOLOGY, MOUNT CARMEL HOSPITAL, TESTIFYING ON BEHALF OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, DETROIT, MI

Ms. ZAMBRICKI. Thank you.

I am Christine Zambricki. I am a CRNA, or Certified Registered Nurse Anesthetist from Michigan. I have a Bachelor of Science degree in nursing, a Master of Science degree in anesthesia, and I am currently employed as the Administrative Director of Anesthesia Services, Mercy Hospitals and Health Services of Michigan. I am also Program Director for a graduate program in nurse anesthesiology at Mercy College of Detroit; I have served as a member of the Governors Task Force on Specialty Nursing for six years and have been the chairman of that task force; and I am also a member of the Michigan Board of Nursing.

I am presenting today on behalf of the American Association of Nurse Anesthetists, which represents 23,000 CRNA's throughout our country.

As many of the members of your committee are aware, CRNA's provide between 50 and 70 percent of the anesthesia services in this country. Between 30 percent and 35 percent of all hospitals are in rural settings, and it is in these settings that the CRNA's practice almost exclusively, providing anesthesia services.

CRNA's are also involved in providing anesthesia services in the military, and in fact the fact that there are not sufficient numbers of CRNA's has been brought up by the House Armed Services Committee as a major concern regarding the Defense Department's military readiness.

In the past two years there has been a pronounced shortage of CRNA's and nurses, and I think that the other presenters have adequately addressed the issue of the nursing shortage. So I would like to spend a little time talking specifically about the current shortage of CRNA's and to make some suggestions as to what can be done.

There are two main factors that contribute to the shortage of CRNA's. One is uncertainty about hospital financing resulting from the Prospective Pricing System, and decreased bed occupancy, which has led some hospitals to decrease their health care expenditures in the area of education.

Hospitals have traditionally underwritten the cost of nurse anesthesia education from the early 1900's until the present, and it is of concern to hospital administrators that the future of hospital financing for education may not be there.

Another major influence which has resulted in either closures or reduction in size of nurse anesthesia educational programs—and this is an important one—has been the diversion of clinical education resources previously devoted to the preparation of CRNA's, to the training of anesthesiologists by chairmen of anesthesiology departments in academic health centers. This latter problem has been detailed in our written testimony, and I will just name a few of the many instances where this has occurred, including, in my own State, the University of Michigan, Johns Hopkins, Duke University, Loma Linda, et cetera—we have listed about 20.

It is primarily the closure or reduction in size of nurse anesthesia programs by hospitals concerned about the availability of educational pass-through funds, and by anesthesiologist chairmen in diverting educational resources to the training of anesthesiologists, that has been the principal cause of the acute shortage of CRNA's that we are now experiencing.

In both 1985 and 1986, nurse anesthesia educational programs graduated approximately 350 less nurse anesthetists per year than were graduated in 1982. Even though more physicians are being trained in the specialty, the number increase over 1972 was only about 290 per year. Therefore, the increase in anesthesiologist has not reduced the need for CRNA's, since from all the evidence that we have there is an increase in CRNA utilization throughout the country.

I know, from my own personal experience, I receive daily requests for information about our graduating class. In my community I can name at least 60 open positions in the City of Detroit, and there is a very intense recruitment effort being undertaken by hospital administrators.

The important part of this testimony is what can this committee and the Congress do to assist in correcting this shortage? There are several suggestions that we have.

First of all, we are suggesting that funding be provided for start-up costs involved in opening a program of nurse anesthesiology. Additional funding should be provided to support students and permit some of that funding for faculty development.

Provide hospital assurance, somehow, that the money in graduate medical education passthrough is appropriately used for nursing education, and specifically for nurse anesthesia educational costs.

Amend Medicare legislation to deter hospitals receiving Medicare funds from precluding availability of clinical training resources to nonphysicians based on their nonphysician status, where both physician and nonphysician programs exist or are being developed.

Perform a review and assessment of the reasons why high school graduates are not choosing nursing as a career.

And finally, since the Joint Commission on Accreditation of Hospitals is mentioned in Medicare legislation, allowing its accreditation to be utilized in lieu of Department of Health and Human Services for proposing eligibility for Medicare funding, undertake to authorize a program review of the Joint Commission. The review should be aimed at determining whether Joint Commission structure and decisionmaking bodies adequately reflect the professions

involved in hospital care and the public, and whether its standards and accreditation process fosters a satisfactory interdisciplinary and interdependent work environment in which the true value and worth of all professions, including nursing, is taken into account, considers cost, and mirrors valid and reliable quality indicators.

Nursing on numerous occasions has been unsuccessful in acquiring representation on the Joint Commission's Board of Directors.

We thank you for permitting us to offer both written and oral testimony to this committee on this matter. We recognize the pressures you are facing. I will try to answer any questions that you may have.

Thank you.

[The prepared statement of Ms. Zambricki appears in the appendix.]

Senator MITCHELL. Thank you, Ms. Zambricki.

I do have a question for each of you. Ms. Curtis, in your testimony you express support for the provision in the legislation now before the House of Representatives which requires an RN for 16 hours a day in facilities of 90 beds or more, and eight hours in facilities of under 90 beds. As you may know, this provision is more demanding than the requirement in my legislation, which requires 24-hour coverage by a licensed nurse, either an RN or an LPN.

In view of the serious shortage of registered nurses, do you believe the House proposal is realistic? Could most nursing homes across the country comply with such a requirement in these times?

Ms. CURTIS. Yes, that does pose somewhat of a dilemma. It seems strange, I am sure, that we would be addressing that proposal at this time when there is a shortage. But we do find it is so essential that we have professional nurse oversight in that particular area that we feel there would be nurses that would be able to fulfill that need, that the population would be able to be addressed so long as the salaries would be satisfactory.

But that is a very limited amount, still, of professional nurse oversight in those areas, and we feel as though that could be accomplished so long as salaries would be commensurate.

Senator MITCHELL. Well, of course that is true if there were no counter limit on salaries. But since most of the nursing homes are limited by reimbursement under existing federal programs for many of their patients, and in view of the stringent budget circumstances here at the federal level and at the State level, do you think it is realistic that they, in the face of the difficulty in gaining reimbursement increases, are going to increase salaries to a point sufficient to attract a large number of new nurses?

If the only problem were higher salaries, and supply and demand existed freely in a free market, then really we wouldn't need this hearing. But it isn't a free market, and there are constraints on the other end. So I wonder whether that would actually occur.

Ms. CURTIS. Well, it is a quality-of-care issue that concerns us a great deal. You know, I understand what you are saying; I just think the quality-of-care issues are of great concern to us.

Senator MITCHELL. Well, it is to all of us, of course. What we are trying to do is to arrive at the most reasonable balance in those two conflicting objectives. I thank you for your comments.

Dr. Towers, you made a point of saying that you serve in a rural area; do you have any specific suggestions as to how to attract nurse practitioners to serve in rural and medically-undeserved areas? If you want to respond now, orally, fine; if you would like to submit a further statement in writing on that specific point, we would welcome that, as well.

Dr. TOWERS. I can do both.

Senator MITCHELL. All right.

Dr. TOWERS. One of the things that we have done recently is to look into the rural and undeserved areas to see just what we have in terms of nurse practitioners. We know there is a shortage, but as we look around we also know that nurse practitioners prepared at the graduate level are indeed functioning in undeserved areas and seem to stay there.

One of the things we were looking at was we were just looking at the States that are represented on this committee and obtaining lists of nurse practitioners who are functioning in undeserved areas, and every State had quite a number. So, I think getting nurse practitioners to stay there is not so much the problem as getting them prepared so they can be there. That is the thing that I think many of these bills address, and we need to make sure that the funding stays there so that we can accomplish that.

Senator MITCHELL. Thank you.

Ms. Zambricki, in your testimony you said there is a current shortage of certified registered nurse anesthetists, which seems to have been caused by a number of factors, including uncertainty about hospital financing because of the Prospective Payment System as well as declining bed occupancy.

You also said, and I quote you, "Chairmen of anesthesiology departments and academic health centers have diverted clinical teaching resources formerly devoted to nurse anesthetist training to increase training opportunities by anesthesiologists."

Do you know what the ratio is of anesthesiologists to certified nurse anesthetists?

Ms. ZAMBRICKI. Are you talking about practicing anesthesiologists and practicing CRNA's in the country?

Senator MITCHELL. Yes.

Ms. ZAMBRICKI. There are about 20,000 of each. There are 23,000 CRNAs and there are about 19,000 anesthesiologists.

Senator MITCHELL. I see. Why do you believe the shift of resources is occurring?

Ms. ZAMBRICKI. Well, I believe it is somewhat political in nature. The chairmen of the anesthesiology departments have control over that resource, and it certainly is in their best interests to expand their residency programs and therefore attain a more powerful position in the structure of the medical schools.

We have seen this happen throughout the country in various States. And as I said, the fact that they do have control over that clinical commodity, that is a very valuable thing when you are talking about educational programs, training health care providers.

Senator MITCHELL. In other words, what you are saying is that when there is a choice between anesthesiologists and nurse anesthetists, the person in the position to decide the allocation of re-

sources is invariably an anesthesiologist and therefore decides in favor of those members of his or her own group?

Ms. ZAMBRICKI. That is right. There is a loyalty there, of course, to the peers. We had that very example occur in Michigan. A University of Michigan program had been in operation for 60 years—a CRNA program. Last year we had a number of hearings relative to the closing of this program, which was initiated by the medical director of the medical school, the anesthesiology program in the medical school. We had over 300 people provide testimony, and this included hospital administrators, surgeons, other anesthesiologists—a wide community of interest for keeping the educational program open for CRNA's. And that was not sufficient to overcome the political power that was present at the medical school. As a result, that program was closed, after a 60-year history. And it had a very good reputation—it was not a quality issue. And they expanded the residency program. They are now looking for CRNA's, like everyone else, because of the shortage that exists in our State.

Senator MITCHELL. As the number of women who are training to become physicians increases, do you think what is happening is that women who previously would have become nurse anesthetists, or nurses, are going to become doctors or anesthesiologists instead?

Ms. ZAMBRICKI. Well, there is no question that there is a trickle-down effect. The fact that less women are going into nursing will impact our numbers.

You may not be aware of it, but 46 percent of CRNA's are men. So, it is a little bit different than nursing in general.

Senator MITCHELL. I am aware of it. I have met with them from my State, and there are usually more men than women who come in for the meetings, with me, anyway.

Ms. ZAMBRICKI. May I just say one more thing that I did not put in my testimony?

Senator MITCHELL. Sure.

Ms. ZAMBRICKI. I would suggest that some consideration be given to diverting some of the funding of physician education to nursing programs and nurse anesthesia educational programs, given the shortage of one type of provider and the so-called "glut" of another type of provider.

Senator MITCHELL. Have you looked at the legislation that I have introduced in this area, S. 1765?

Ms. ZAMBRICKI. Yes.

Senator MITCHELL.Well, thank you all very much.

I am pleased that we have been joined now by Senator Durenberger, who served as Chairman of this subcommittee with great distinction for six years and is responsible for much of the progress that has been made in legislation affecting health care in this decade.

I would now call on Senator Durenberger, if you have a statement or questions for this panel.

OPENING STATEMENT OF HON. DAVID DURENBURGER, U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you. I do have a brief statement.

I thank you for the opportunity for us to learn about the problem of nursing shortages and to start a process of determining not only the nature of the problem but some of the solutions.

I happen to think the solutions are not easy to arrive at. They don't all involve increased reimbursements; they really do involve recognizing the role that nurses play today and will play tomorrow, rather than what they have played in the past.

If there is one area in which needs change quickly, it is medicine, and it is too easy to neglect the changes and capabilities as they are required to match those needs.

The number of nurses educated in the schools of nursing has grown dramatically in the past 30 years; but the fact is, our unmet needs for nurses is still increasing rather than decreasing. The problem, it seems to me, is not due to any past failures to train or to recruit nurses; rather, the current shortage reflects a greatly increased demand more than it represents the declining supply .

There are several reasons for the higher demand:

Because of changes in medical practice, hospitalized patients are sicker and require higher levels of professional care than they have in the past;

Compensation and work environment changes for nurses have not kept pace with the changes in the medical delivery system, or the nursing home system, or competition from other seemingly more attractive employment in other parts of the marketplace;

And finally, the specialized abilities of registered nurses are not being utilized as they should be in this health care delivery system.

Under current management practices, these professionals with increasingly sophisticated education, technical training, are required still to perform many non-clinical tasks. This inhibits their ability to provide high-quality cost-effective patient care. And in the process, resources are wasted and nurses have low levels of job satisfaction.

These facts are well documented, in particular in an excellent article by Dr. Linda Aiken and Conniee Mullenix entitled "The Nurse Shortage—Myth or Reality?" in the New England Journal of Medicine, which, Mr. Chairman, I would like to submit for the record, if it hasn't already been done.

[The article appears in the appendix.]

Senator DURENBERGER. To solve these problems, I believe a radically different approach is needed, one that recognizes the vastly increased options that people, especially women, today have to choose other careers. Nursing must compete with a variety, and a growing variety, of other societal requirements.

The future will be better only if the levels of professionalism and autonomy are high and the practice environment is challenging and rewarding.

The world for women has changed, and I am proud to help accelerate that change by pushing hard for economic and other equity for women in legislation since I first came to the Senate, beginning with the Economic Equity Act, which today is S. 1309, The Economic Equity Act of 1987.

For these reasons, I have today introduced the Medicare Nursing Practice and Patient Care Improvement Act of 1987, S. 1833. By funding projects to demonstrate and evaluate innovative nursing

practice models, this bill will encourage hospitals and nursing homes to utilize registered nurses as patient care managers, increase nurses' roles in facility administration, develop career progression opportunities for nurses, and improve working conditions to retain and attract the highest quality nursing staff.

My own State of Minnesota has had excellent experience in using professional nurses as case managers. Currently, all 87 counties in Minnesota are using RNs as case managers for Medicare beneficiaries. These nurses are helping seniors and their families to make informed decisions about their care, helping people stay out of nursing homes, promoting independence, helping to ensure high-quality cost-effective health care for Minnesota's senior citizens.

By translating this experience into the hospital and long-term-care setting, we will improve job satisfaction and foster recruitment and retention.

We in the Congress know from the past that quick fixes to nursing shortages have only served to create long-term problems. Our challenge today, then, is to find solutions not for the present but also for future generations.

Thank you.

Senator MITCHELL. Thank you, Senator Durenberger.

Thank you very much for your participation.

The next panel consists of four persons: Charles Jenkins, President of the Union Memorial Hospital of Baltimore, and Margaret L. McClure, Executive Director of Nursing at New York University Medical Center and past President, the American Organization of Nurse Executives, who will be testifying on behalf of the American Hospital Association; Margaret Cushman, President and Executive Director of the VNA Group, testifying on behalf of the National Association for Home Care; and Dr. Paul Willging, Executive Vice President of the American Health Care Association.

Good morning. ladies and gentlemen, and welcome.

Mr. Jenkins, we will begin with you.

STATEMENT OF CHARLES D. JENKINS, PRESIDENT, UNION MEMORIAL HOSPITAL, BALTIMORE, MD, ACCOMPANIED BY MARGARET L. McCLURE, RN, ED.D, EXECUTIVE DIRECTOR OF NURSING, NEW YORK UNIVERSITY MEDICAL CENTER AND PAST PRESIDENT, AMERICAN ORGANIZATION OF NURSE EXECUTIVES, NEW YORK, NY, TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION

Mr. JENKINS. Thank you, Mr. Chairman.

I am Charles Jenkins, a former member of the AHA Board of Trustees, President of Helix Health System in Baltimore Maryland. Helix hospitals are teaching hospitals and are significantly engaged in nursing education.

I am pleased to be here today to discuss with the committee AHA's concerns about the nature and extent of the nursing shortage.

With me is Dr. Margaret McClure, who will discuss the role we believe the Federal Government can play in attempts to alleviate it.

The shortage is real. Unlike previous nursing shortages, this one cuts across all levels of nursing, all types of hospitals, and all areas of the country. Vacancy rates for RNs in hospitals doubled between 1985 and 1986 and are now running 15 to 20 percent, and on an individual basis much higher.

Nearly one-fifth of all hospitals responding to an AHA survey termed their shortage "severe." Hospitals are resorting to agencies to fill vacant positions. This runs up costs and puts strangers at the bedside.

It is first a problem of supply. The applicant pool to all nursing programs is down; other careers promise more money, more prestige, and better hours. The 20-percent nurse turnover rate in hospitals is a reflection of noncompetitive pay, increasing workloads, and limited upward mobility.

Hospitals are spending millions just to recruit and train nurses to fill vacancies. Moreover, hospitals today employ more RNs as compared to LPNs and aides.

Coupled with this supply problem is one of demand. Today's hospital patients are sicker. This greater severity of illness requires a more intensive level of nursing service. The ratio of nurses to patients has increased dramatically, and it should have. The elderly are hospitalized more frequently and stay in longer, and this segment of the population is the fastest growing. They require more labor-intensive nursing services.

Other industries respond to manpower shortages by upping the ante. One of our trustees suggested we should simply pay more, and he is right, we should; but ours is a regulated industry, and we cannot raise pay adequately when the revenue side is constrained.

The Medicare program has put us on short rations. We need your help in assuring adequate Medicare funding for hospitals and federal support for various initiatives, which Dr. McClure will address.

Thank you.

[The prepared statement of Mr. Jenkins appears in the appendix.]

Senator MITCHELL. Thank you very much, Mr. Jenkins. You established a commendable level of brevity, which is rare in this group.

Mr. JENKINS. I apologize. [Laughter.]

Senator MITCHELL. No need to apologize.

Dr. McClure?

STATEMENT OF MARGARET McCLURE

Dr. MCCLURE. Thank you. I am Margaret McClure. I am the Executive Director of Nursing at NYU Medical Center in New York City. I do want to reiterate what has been said by Charley and by many others in this room today, in that the need for skilled nursing personnel and the demands placed on those personnel has certainly been increasing over time and has been well documented.

We would urge that the Congress continue to resist any attempt to cut funding to nursing education, as it has in the past—and I will tell you, we do applaud you for that.

In order to attract and maintain qualified individuals in undergraduate nursing programs, it is essential that federal funding and financial aid for entry-level and advanced nursing education be increased. Also, targeted funds to support educational mobility for the more than 450,000 Licensed Practical Nurses in the country are needed as hospitals shift the skill mix of their nursing staffs in favor of Registered Nurses.

AHA recognizes the need for innovative programs to address both retention and nursing care delivery, and we are very pleased to hear about the introduction of the bill, Senator Durenberger, and we will certainly support it.

We also support studies and demonstrations of any kind that will help us to find innovative and creative ways to retain qualified nursing personnel in our settings. Making funds available to educate additional people will not solve the problem unless we, of course, do that retention piece.

I would like to tell you that AHA has been applauding your efforts to formulate potential solutions to the nursing shortage. We believe your bills both contain provisions that can help to address the shortage.

We also support the concept of Medicare grants and contracts for developing innovative nursing care delivery systems, as embodied in your legislation, and we look forward to working with you on these matters, if we can be of any help.

Thank you.

Senator MITCHELL. The next witness is Ms. Cushman. Welcome, Ms. Cushman, we look forward to hearing from you.

STATEMENT OF MARGARET J. CUSHMAN, RN, MSN, PRESIDENT AND EXECUTIVE DIRECTOR, THE VNA GROUP, INC., TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION FOR HOME CARE, WATERBURY/HARTFORD, CT

Ms. CUSHMAN. Thank you.

My name is Margaret Cushman. I am President and Executive Director of the VNA Group, Incorporated, serving Greater Hartford and Greater Waterbury, Connecticut. I also serve as Chairman of the Board of Directors of the National Association for Home Care. The National Association for Home Care represents 5,000 member hospices, home care agencies and homemaker home health aid agencies.

We commend you for holding this hearing, and I would commend both Senators for your knowledgeable and articulate introduction of some of the key issues in the nursing shortage that has been plaguing us.

Certainly, the nursing shortage is not new. There are two characteristics of this shortage that were not evident in prior years.

The first characteristic is the decline in enrollments in schools of nursing, and the second is the spread of the nursing shortage throughout all nursing settings. It has already hit the nursing home, the community health, and the home care settings.

For home care providers, the shortage of registered nurses at a time when patient caseloads and acuity levels are increasing, along with additional pressure for and emphasis of quality assurance, is

disastrous. Experienced nurses are scarce, and nurses with community health and acute care experience are even harder to find. Those folks are necessary to care for today's patients.

During previous shortage years, nurses frequently left hospital employment settings to work in community health and home care, even though salaries were frequently $,1000 to $3,000 less per year. The nurses found that regular hours, no shift work, weekends off and no evenings and nights were well worth the difference.

Home care is no longer like that today. Nurses work evenings, weekends, nights, and difficult cases. Cases that just a few years ago one would not expect to have been taken care of at home, requiring a very acute level of skills, are being cared for at home on a regular basis.

Previously, community nursing settings were more autonomous, more devoid of physician domination, and provided opportunities for independent clinical decisionmaking by professional nurses. They were able to practice in a professional model. Community health nurses were also usually minimally baccalaureate-prepared, and generally they entered with at least one-year experience from hospital settings. Today many of these attractions are absent from community health settings, and patients who were once thought to be totally unmanageable at home are forced to receive home care under circumstances where we, too, are having difficulty attracting qualified nurses.

Nurses find that they visit their patients and then, because of a lack of time, take their paperwork home with them. They cannot delegate paperwork today because the nature of the paperwork requires that they complete it, answering requests for additional information related to the increased denials in home care services. This time spent in unnecessary paperwork inappropriately cuts into home care time and reduces satisfaction among the nursing staff. Even after submission of excessive paperwork, nurses are discouraged from having care unnecessarily denied which, in their professional judgment, is warranted.

The shrinking pool of baccalaureate nurse graduates poses a real threat to community health agencies, because BSN nurses previously were the only ones receiving the necessary community health education. In addition to needing the community health education, we need nurses prepared with acute-care-setting experience.

Solving the problem of the nursing shortage is not going to be easy. It has its roots in the profession's public image, poor employer-employee relations, and the gender-dominated nature of the profession.

Solutions have been posed in the past, and while some employers of nurses have implemented suggested remedies, nationally, the profession is underpaid, overworked, and undervalued for their contributions to health care.

The average starting salary for a nurse still tends to be problematic, in being low, but the maximum is even more problematic for experienced nurses. The DRG System has certainly compressed the payment ability of hospitals, constraining their resources, and the cost limits and the huge and growing number of denials in home care have operated to keep salaries down.

The marketbasket and wage and labor index used for home health care cost limits is completely out of touch with the rapidly escalating nursing wages.

Solving the problem of the nursing shortage is not going to be easy. Nationally, the profession—as I mentioned—is underpaid, overworked, and undervalued. Today's nurses want income, autonomy, respect, and improved working conditions.

The solutions to the nursing shortage are not new: Increased wages, federal support for nursing services, support services so nurses may concentrate on patient care, and federal support for nursing education are essential.

We applaud the introduction of S. 1402, the Nursing Shortage Reduction Act of 1987, as a first step in this direction. In addition this legislation, we hope that immediate attention will be given to the issues, which have been proven problematic over a decade ago and continue to be problematic today. The restructuring of the entire health care delivery system may be the only alternative.

Thank you for the opportunity to testify.

[The prepared statement of Ms. Cushman appears in the appendix.]

Senator MITCHELL. Thank you, Ms. Cushman.

Our next witness is Dr. Willging, a frequent witness before this committee and one who always provides us with valuable advice and information.

We look forward to hearing from you again today, Dr. Willging.

STATEMENT OF PAUL R. WILLGING, PH.D., EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, DC

Dr. WILLGING. Thank you, Mr. Chairman, and thank you for the opportunity to discuss what is clearly, in the health care environment, one of the most critical issues we have yet faced. Indeed, it is an issue that is no longer cyclical, is no longer periodic as the nursing shortage has been in years past; it is chronic. It is here to stay. It is going to get worse.

Unfortunately, I think attention devoted to the nursing shortage until very recently has been oriented largely toward the acute care setting. One of the reasons we greet the introduction of your legislation, Mr. Chairman, Senate Bill 1765, is the clear recognition that, difficult as the problem is in the hospital sector, it is even more serious with respect to long term care, and the impact of that serious issue, I think, are even clearer with respect to long term care.

The nursing home industry has more patients, there is already less interest on the part of nurses and nurses in the academic environment in serving in long-term care institutions, and, as has been indicated previously, we have much less in the way of resources to pay nurses what they are worth.

Now, the results are obvious: 75 percent of our members recognize nursing shortages in the areas in which they operate, 58 percent of our members report nursing vacancies, one-third of our members cannot in fact meet minimal staffing requirements estab-

lished by Federal and State Governments in the absence of double shifting, a pool of nurses, and other less than effective solutions.

The industry does not—as one of the previous witnesses has suggested—refuse adamantly to increase its staffing levels. The industry does not refuse to pay reasonable wages, and it does not pay reasonable wages to nurses. As you have aptly pointed out, Mr. Chairman, the industry I represent is largely dependent on the Medicaid program for the bulk of its revenues. It does what it can, given the nature of those revenues.

Our concern, therefore, is solutions which would simplistically mandate approaches which might or might not work in the acute-care setting but will only exacerbate the problem in long-term care.

To mandate increased RN staffing in nursing homes, above the reasonable and practical levels contained in your legislation, Senate Bill 1108, would simply create a much more serious problem and not at all deal with the issue as it exists today.

Seventy-five percent of all nurses in nursing homes in this country are not Registered Nurses; they are Licensed Practical Nurses. They are Licensed Practical Nurses because that is the form of nursing care that the industry can afford given its dependence on the Medicaid program. And to mandate simply increased staffing levels based on the RN concept will simply force that many more nursing homes out of compliance and further erode public confidence in the care provided in America's nursing homes.

Given that dependence on Medicaid, we cannot recruit—and I suspect the country is at this point unwilling to afford—predominate RN staffing structures in nursing homes. A recent study in the State of Kentucky indicated that predominate RN staffing programs in nursing homes will add $9 per patient day, costing the nation $5 billion additional per year. If the funds are available, we would be happy to comply. Until the funds are available, I think that type of mandate will simply, as I suggested, exacerbate, not resolve, the problem.

I think our efforts as we attempt to resolve this issue must recognize that, if indeed the health care industry is heterogeneate, the so too must be the solutions. If indeed there are multiple forms of care provided in the health care industry, so too can the form of health care provision reflect different types of health care providers.

So, we would suggest that any solution recognize that there are multiple types of nursing, that they do indeed function adequately, that given the higher acuity levels in the nursing homes, yes, additional RN staffing is required.

We greet, we have supported, we have worked with you and your staff, Mr. Chairman, to recognize that in Senate Bill 1108. But I think the solutions must go beyond simplistic approaches. We must recognize the reality of the marketplace, recognize the reality of the labor pool, and must recognize the reality of the reimbursement mechanisms.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Willging appears in the appendix.]

Senator MITCHELL. Thank you, Dr. Willging.

I would like to ask Mr. Jenkins and Dr. McClure: The available data on the nursing shortage is not as complete as we would like. Some analysts suggest that rural hospitals may not have as serious a nursing shortage as urban hospitals. Do either of you believe that to be the case?

Mr. JENKINS. The AONE did a survey I believe in 1986, some of the findings of which support that contention, that the problems, though serious as I indicated, cut across all segments of hospitals in this country, but they are apt to be more serious in larger hospitals, more serious in urban hospitals, and a bit less so in rural. But that doesn't mean the rurals don't have a problem; they do.

Senator MITCHELL. There seems also to be a difference of opinion on the question of the level of training of hospital nurses. Some advocate a move to total coverage by RNs, and there is some data to suggest, particularly with respect to nursing education, that that is occurring. Do you think there will continue to be an important role for the LPN and the diploma-school graduate in the next decade and beyond?

Dr. MCCLURE. I think what we are finding as to what has happened in hospitals, most of us have found that with the technology changing, the knowledge and skill level for Registered Nurses is rising all the time.

The question is whether or not, in fact , we can have people with enough knowledge and skill at the bedside for the very acutely ill patients we now have to take care of those patients safely. This is one of the reasons in our testimony we talked about upgrading the LPN. We are very concerned about this large body of people who have potential to serve those patients well but who really do need a greater level of skill and knowledge.

I think one of the problems we know in hospitals is that the biggest job the Registered Nurse does is to monitor the patient constantly and figure out if he is going along normally or getting into trouble. It does require a level of knowledge that does not readily come for the lesser-trained person. And I suspect that one could find a very high negative correlation between the quality of the nursing staff and the numbers of negative consequences for patients that shouldn't have happened, unnecessary negative consequences.

So, that is one of the reasons why hospitals have tried to move toward more Registered Nurse staffing. And I think, to the extent that they are able, they would like to continue in that direction.

Senator MITCHELL. Thank you.

I would like to ask Ms. Cushman: In Maine and in many parts of the country, possibly including yours, there has been a dramatic increase in the number of home health care denials under Medicare. If you have had that experience in your area, do you think the increase in denials plays any role in the burden of the home care nurse and in the diff iculty of home care agencies to recruit and retain nurses?

Ms. CUSHMAN. There is no question. It is having a very significant impact. I would comment for my agency in the State of Connecticut. We are just now moving into a change in intermediary, which is causing a major problem in this regard, through the regionalized intermediaries.

We find our nurses are frustrated, upset. The care that they know their patients need and have received in the past is being refused apparently arbitrarily and without pattern. It is increasing their paperwork—they are spending hours in the office and spending hours at home completing additional information—and still they are having care denied.

Senator MITCHELL. Thank you very much. I am going to have a hearing in the near future on that subject, as well, because that has been a matter of real concern across the country and particularly in my State, which has had, unfortunately, the highest denial rate in the country.

Dr. Willging, you commented on some of the legislation and the requirements for nursing home coverage and that the shortage has been a problem for nursing homes. As you know, we recently adopted in this committee's Reconciliation Bill the provisions of S. 1108. Do you think that the requirements of that bill, which include 24-hour licensed nurse staffing and at least one full-time RN can be met by the nursing home industry?

Dr. WILLGING. I think with difficulty those requirements can be met, Mr. Chairman, and I think you have also recognized that there will be areas in the country where, try as it might, the nursing home cannot find the nursing personnel required. And you have allowed for certain waiver provisions when that does in fact take place.

I think you have recognized the reality of the need for increased nurse capability and staffing in nursing homes, and you have in effect accepted the recommendation of the Institute of Medicine. You have also recognized the reality of the labor market and the reality of reimbursement systems and have chosen not to go beyond what is realistic today, and we commend you for that.

We will do our best to meet the provisions of that type of legislation and, as I say, with difficulty I think we can.

Senator MITCHELL. Thank you very much.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I guess there are a lot of questions that can be asked around this issue that we aren't going to be able to tackle today, but the first one I think I would like to ask deals with the function of federal financing of education.

I guess I have heard a lot of people recommend—and I heard it from at least one member of this panel—that the Federal Government needs to do better in financing education for persons going into this profession.

I know my first reaction to that, when I heard it back home, was why should we pay people to get an education in nursing and then have them go out and go into some other field? If you look back on the track record of the Federal Government trying to pick the winners and losers in the marketplace and finance only the winners, it never seems to work out—at least, we always seem to get behind the curve.

So, I happen to be one who thinks the Federal Government ought to play a different federal role in financing access to higher generally, and for post-secondary education, let me put it that way. I don't have a fetish for the BA like a lot of people do, particularly

as we look into the future. I think there is a place for the baccalaureate, but I think there are an awful lot of other areas in which post-secondary education is needed and can be utilized, and we don't have to put everybody through a BA program and thus, in effect, make them available for a wide variety of opportunities, if in fact we are looking at the national government's responsibility in financing access to education.

So, I guess the first thing I would be looking at is sort of a defense of why should the Federal Government be putting more money into nursing education, and what should our expectations be if we do? Is there a different or a better way to fulfill capitation programs, to finance access to education?

Dr. McCLURE. I would like to answer a little bit, if I can. I will try, Senator Durenberger.

First of all, one of the myths that is out there is that people who are Registered Nurses leave nursing in large numbers, and that in fact is not supported by the data. It is one of the myths, however, that, you know, they are out there selling real estate, or whatever.

Senator DURENBERGER. Oh, there is a bunch of them back in the back row back here.

Dr. McCLURE. You are doing your job to cause the nursing shortage in this country. [Laughter]

Seventy-eight percent of the people who hold RN's are practicing, in fact, in nursing. That is probably a higher percentage than other occupations for which people train.

I think we have two problems in nursing. One of them is that there are so many opportunities. You certainly have only to look at the data for a second to figure out that. In fact, we use huge numbers of nurses, every year more and more. That is one problem.

The second problem is that we are a predominately female occupation, and nursing is uniquely wonderful for women in that they can work part-time and take care of their families part-time, and in fact that is what they do.

The part-time issue is a factor in our shortage, in that many people do work part-time rather than full-time. But apparently the data is not supportive of the notion that people leave nursing who have been educated in nursing, in fact they spend a fare amount of time in it.

Dr. WILLGING. Can I take another crack at that, Mr. Durenberger? Because I know you love the concept of the free market economy, so I will try that one on you.

If indeed health care were a free market, one would probably argue that the market should take care of the problem. But the Government sets prices in health care, and by setting prices it impacts obviously and to some extent detrimentally on the labor pool. Ergo, since it is the Government's responsibility to set prices, ergo it must also deal with some of the glitches of that that price structure it has established creates.

I think one can argue about the mechanisms and modalities whereby one would in fact deal with the labor market. One of the suggestions we have made is to regenerate the loan forgiveness provisions, which would in effect force people to stay in the profession they have chosen, at least until such time as the loans have been forgiven. But I think there are to deal with the issue.

Senator DURENBERGER. Let me ask Mr. Jenkins about the behavior of hospitals. Paul has foreclosed me from asking him by saying that you don't pay enough, and that we have set price controls for the nursing homes, so they don't have any flexibility.

But the hospitals that I go through around the country have some flexibility, and my question of you is, why don't hospitals do things about increasing nursing salaries? Particularly as they go through a variety of skills requirements, why do they pay the same in a lot of hospitals for weekend duty or late-night duty that they pay for other duty? Why don't they change the work environment? Why don't they give the doctors in surgery the same as nurses who know the particular procedure, with each special kind of surgery? Why don't hospitals do more with what they have to increase the level of job satisfaction for nurses?

Mr. JENKINS. Thank you for that opportunity, Mr. Durenberger. [Laughter.]

It is not that they don't; I think they do, and they do with varying degrees of persistence and varying degrees of expertise and sophistication, and therefore with varying degrees of success.

I think I won't try to enumerate each of the subquestions. I would suggest to you, however, that the underlying thrust of your question is that hospitals indeed have flexibility. That is a very relative term.

Medicare and Medicaid do not pay their fair share. There is an extremely large number of people in this country who in my judgment, because they are impoverished, ought to be under Medicaid programs but aren't, because the levels in the State programs aren't sufficient to cover them. So, hospitals have to bear the burden of inadequate Medicare payment, inadequate Medicaid payment, and inadequate payment for those patients for whom there is no sponsor. They can play Robin Hood only so much, because who do they turn to with that flexibility other than the almost-vanished self-paid, truly paying, patient, plus the insured patient?

Industry in this country has awakened to the fact that it is inappropriate for them to get dumped on in this fashion, and industry feels, and I think rightly so, that all ought to come forward and pay their fair share. Even industry itself can be segmented into the payers and the nonpayers. Many employers in this country, particularly the smaller ones, do not carry adequate health insurance, and the employers and the industries with whom they compete are helping to pay for their failure to be responsible old employers.

Senator MITCHELL. Thank you very much, Senator Durenberger. We are pleased that we have been joined by Senator Rockefeller, whose contribution in the area of health care has been very significant, and who has played a major role in much of the legislation that has been moved out of this committee this year.

Senator Rockefeller?

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Thank you, Mr. Chairman. I apologize for being late.

West Virginia, I guess, is like a lot of other States in terms of suffering shortages of health case provides. If you look at the nationwide statistics it appears that the average starting salary for nurses is around $21,000. That goes on up to say $28,000. But it stops at $28,000.

I hear—and I don't know whether this is true or not, but this is what I have been told, and I would be glad to have your views on it—that basically there's a cap on the salary a nurse can hope to make after being in the profession for 15 or 20 years in this country. The cap amounts to being able to make no more than $28,000 on the average. Now, I can see where that might be a disincentive for a young person considering nursing when thinking about the future. In other words, you look at what the future holds, and you say, "Well, the salary is pretty good to begin with, but after 20 years of service I am going to make only $28,000, and that doesn't provide me with much of an incentive," whether that person is a man or a woman.

What is the situation? Within the hospital community, is there in effect an average "cap" on let us say the salary for lab technicians, or those who do accounting or other kinds of work, or those in management? Or is the cap a unique phenomenon for nurses?

Mr. JENKINS. I am not aware, Mr. Rockefeller, that the wage and salary administration processes and rules in hospitals differ for nurses than for others. I think that one of the big difficulties financially is that nurses are in such predominance in hospitals. There are many, many more nurses than there are the other occupational groups which you mentioned. And therefore, a $1 raise for one category has a minimal effect on the hospital's budget overall; whereas, a $1 raise in another category such as nursing has a whale of an effect, and this is an economic fact of life that people have to live with.

We agree with you that nurses are not paid enough and ought to be paid more.

Senator ROCKEFELLER. Well, one always can make that point. But seems to be true on a nationwide basis that the average salary for nursing simply stops going up at a certain point. I mean, in most other skilled professions, salaries keep going up until retirement. And it appears that in nursing the salaries don't go up beyond a certain average amount, which has to act as a disincentive when people plan their careers. I mean, it is like anything else.

I want to see more men go into nursing. I don't understand why they don't and I want to talk with you about that in a moment. But people make their judgments in part about what they are going to do based upon what they think the financial opportunity is, and they make those judgments when they are very young, and that has to do with what people believe their pay will be. Twenty-one thousand dollars a year is not bad for a beginning, but $28,000 after being in the profession for 20 years, probably isn't impressive.

Maybe somebody else has a comment on that.

Ms. Cushman.

Ms. CUSHMAN. I would suggest that you are accurate in that perception, and that one of the problems relates to what I mentioned earlier in my testimony, the undervaluing of the nursing profession. Whereas, other professions on entry level may be somewhat

comparable to nursing, the other professions have other ways to remain in their professions and move into higher salary brackets further down the line.

But one point: When nursing was considered predominately a women's profession, one of her potentially two to three choices, the maximum salary might not have been as much of a factor for entry. It is now that women and others have many other professions to choose from. So, if a nurse continually remains on salary within a fixed setting, the system has undervalued the maximum worth of that. As we need more baccalaureate and higher-degree prepared nurses, this is becoming more problematic.

Senator ROCKEFELLER. People say that nursing is a women's profession, and since I have arrived, that has been indicated by the panel. There are more women now, I am told, in medical school nationwide than there are in nursing schools. At West Virginia University in our School of Nursing, out of 72 in our class this year, three are men. Now, I don't understand why that is. I mean, this is a wonderful pursuit in terms of service to the people, and there are still a lot of people in our country who are motivated by human service, being able to help people, and nursing clearly, clearly ranks high in that.

Now, the pay and working conditions and all of that can be difficult; but, nevertheless, there are a lot of people in this country who want to serve other people. There are a lot of people who can't find jobs. And I don't understand why it is that men haven't been more anxious to participate in nursing. They used to say that about elementary school teachers, and now when you go to an elementary school you see more men, and I feel very good about that. I don't know why it is that there are only three out of the 72 of the West Virginia School of Nursing this year who are men. Can you help me understand that more?

Dr. MCCLURE. I think, Senator, there are a couple of problems, one of which is that nursing and being a male has always had sort of a stigma attached to it. In fact, when people would talk about someone being a nurse, if that person was a man they would call him a "male nurse." It was always a big issue that the person was a male. And I think that stigma remains today.

It is very difficult for a man to elect an occupation that essentially has all the female connotation that nursing has.

The second issue of course is the salary piece, and whether or not in fact a person feels that he can enter the field of nursing and know that he will be a good breadwinner for a family in years to come. That is an issue.

Senator ROCKEFELLER. One more indulgence, Mr. Chairman, on that first point.

Is that stereotype breaking down, though? I mean, if you want to look at it, we can sit here and criticize $21,000 as an average starting salary, and on the other hand you can look at it from the other point of view, and that is that there are a lot of people in this country who are out of work, who are male, to whom $21,000 is a lot better than not having $21,000. It is a profession demanding hard work but it also represents service and has social values. Now, is that stereotype that inhibits men from being nurses breaking down

as it clearly ought to? It doesn't make sense to me. "Stereotype" doesn't sound like an adequate description to me.

Dr. McCLURE. I think that is why I put it first, because I think for some reason it remains the problem. I regret to say that, but I think it is the case. I think it is too bad. We have more numbers of men coming into nursing, but we still haven't gone over 3 percent, which reflects what you just talked about in your own data.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Rockefeller, and thank you, ladies and gentlemen, for your participation.

The final panel will consist of Nancy Greenleaf, Dean of the University of Southern Maine School of Nursing, testifying on behalf of the American Association of Colleges of Nursing; and Dr. Neville Strumpf, Assistant Professor and Director of the Gerontological Nurse Clinician Program of the University of Pennsylvania School of Nursing, testifying on behalf of the National League for Nursing.

I thank you both for coming. Before calling on Ms. Greenleaf, I would like to recognize the presence of our distinguished colleague Senator Chafee and ask whether you, Senator Chafee, have any opening statement you would like to make.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Mr. Chairman, I will submit it for the record; but first, I want to congratulate and thank you for holding these hearings. Hopefully, we will find some solution to this difficult problem.

We are encountering it in my home State where, in one of our major hospitals in the City of Providence, a whole floor has had to be closed because of the inability to obtain nurses.

So, I will submit my statement as we seek solutions in this fine hearing you have arranged today, Mr. Chairman.

Senator MITCHELL. Thank you, Senator Chafee.

We will begin, then, with Dean Greenleaf.

Welcome. It is always nice to hear a responsible voice from Maine at these hearings.

STATEMENT OF NANCY P. GREENLEAF, RN, DNSC, DEAN, UNIVERSITY OF SOUTHERN MAINE, SCHOOL OF NURSING, TESTIFYING ON BEHALF OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING, PORTLAND, ME

Dean GREENLEAF. Thank you, Senator. I am pleased to be here.

I am Dr. Nancy Greenleaf, Dean of the Nursing Program at the University of Southern Maine in Portland, Maine.

I am pleased to present this testimony on behalf of the American Association of Colleges of Nursing, which represents more than 400 university and college-based baccalaureate and higher degree schools of nursing.

Our Association is deeply concerned about the current and growing nursing shortage, and we applaud your efforts to determine the nature of the problem and potential solutions.

In the academic year 1985-1986, baccalaureate programs—this is nationally—experienced a 4.5 percent drop in enrollment. This was the first time there was an indication of declining interest in nursing as a profession. In the academic year 1986-1987, baccalaureate programs experienced a 12.6 percent decline. This second, more precipitous decline was the largest percentage decline in several decades. This year our association has just begun to analyze the data for student enrollments in baccalaureate programs. Early indications exist that for the third year in a row enrollments in schools of nursing will again show large drops.

As many before me have said, women are no longer constrained by limited views of what is an appropriate career choice. I am sure you have heard the statistics, and I know you have, that indicate that as enrollments in nursing have declined, the numbers of women enrolling in engineering, law, medicine, accounting, and business have skyrocketed. Young women today are seeking professions which they perceive as more likely to provide both prestige and monetary rewards. Many individuals simply do not perceive nursing as a career that is of high social prestige. Moreover, the salaries that nurses receive are often not reflective of the tremendous responsibilities and high level of education that nurses require.

The solutions to the complex problem surrounding the nursing shortage must be complex themselves, as you have said, Senator Mitchell. Simply providing support for individuals who are entering nursing education programs will not make the shortage disappear. This is not to suggest that educational support is no longer necessary; we do believe the costly nursing education experience must be supported in new and creative ways. In addition, we must improve the work environment for nurses.

Our Association would therefore like to commend you, Senator Mitchell, for your innovative and wide-ranging approach to the nursing shortage in S. 1765.

The inclusion of the initiatives to provide direct reimbursement for nursing services under the Medicare System is an indication of your awareness of the importance of nursing in the health care system. Nurses should receive direct reimbursement for the high-level quality care provided to the elderly or the disabled.

Of greater importance to the Association, however, is your awareness of the need to support the cost of clinical training for graduate nursing education. The shortages that exist for the basic level practitioner are also present for the advanced level clinician. The fifth report to the President and Congress by the Secretary of the Department of Health and Human Services predicted a shortfall of 200,000 nurses prepared at the advanced graduate level by the year 1990. This shortfall will increase to 335,000 by the year 2000. Coupled with the projected increases in elderly populations, these figures reveal a need to strongly support both graduate and undergraduate nursing programs.

I want to say that these shortfall figures are probably conservative, particularly given the estimates we now have of the interest of people for the profession at the beginning levels.

The current medical education funding available through the Medicare system does provide support for many basic-level nursing

programs; however, when providers have attempted to engage in collaborative arrangements with academic institutions for the purpose of supporting clinical training activities for nurses, Medicare pass-through support has often been denied. Many hospital providers are aware of the positive effects which accompany clinical training for graduate nursing students.

The faculty who accompany graduate nursing students to clinical service agencies also provide expert consultation regarding complex patient care problems; yet, the faculty are not reimbursed by either the patients receiving the benefit of these services or the provider clinical agency. Instead, faculty salaries are almost exclusively provided by the academic institution in which the student is enrolled. Many providers recognize the value of supporting these clinical training activities and provide resources to the academic institution, and incur costs to assist this training.

Senator MITCHELL. Excuse me. A vote has just begun in the Senate, and I am going to leave to go and vote. Senator Chafee will remain, and will try to keep the hearing going, if we can.

Dean GREENLEAF. All right.

If clinical service agencies incur costs in support of graduate nursing education, some relief in the form of Medicare support for graduate nursing education should be provided. The justification for requesting this support is that clinical training cannot occur in the absence of service to patients. The inclusion of practical patient-care experience is central to clinical education. The support of nursing education by a system of health care reimbursement designed to assist the elderly is in deed appropriate.

Our Association recognizes the serious consequences of an escalating nursing shortage to our nation's elderly and the health care needs of all individuals. We applaud your efforts and the committee's efforts on behalf of our nation's health care needs. We support your efforts to introduce new and innovative solutions to the nursing shortage.

Solutions to the shortage must include initiatives to improve the practice environment and enhance support for individuals seeking a career in nursing.

In closing, we offer our support in developing additional solutions that will help all of us find answers with long-term effects. Nursing recognizes its responsibility to assist in overcoming the problems identified. Our Association is engaged in numerous activities to enhance recruitment into the profession; however, without your efforts to enhance the work and educational opportunities for nurses, recruitment will be futile.

Thank you.

[The prepared statement of Dean Greenleaf appears in the appendix.]

83-151 0 - 88 - 2

STATEMENT OF NEVILLE E. STRUMPF, RN, PH.D., ASSISTANT PROFESSOR AND DIRECTOR, GERONTOLOGICAL NURSE CLINICIAN PROGRAM, UNIVERSITY OF PENNSYLVANIA SCHOOL OF NURSING, TESTIFYING ON BEHALF OF THE NATIONAL LEAGUE FOR NURSING, PHILADELPHIA, PA

Dr. STRUMPF. Senators, I am Dr. Neville Strumpf, Assistant Professor and Director of the Geriatric Nurse Practitioner Program of the School of Nursing at the University of Pennsylvania.

Today I am testifying on behalf of the National League for Nursing, which is the official accrediting agency for nursing education and represents approximately 2,000 agencies and 15,000 individuals dedicated to improving the quality of health care through nursing education.

We have already heard discussed the proposed bills from this committee, and I heartily endorse them. As you have our testimony already, which does emphasize many of the problems of the nursing shortage in acute care, I would like to make some departures in-to the long-term care arena, since that is what I have devoted the past five years of my career to doing, encouraging undergraduates to consider careers in aging as well as preparing Nurse Practitioners for practice with the elderly, hopefully in nursing homes.

It is not new to anyone here in this room that only 8 percent of active RNs work in nursing homes, and that we are only able to recruit, at best, 5 percent of our current graduates to even consider a career with the elderly.

In 1986 there were exactly 601 geriatric nurse practitioners certified by the American Nurses Association and working in this country. That is a very paltry number, indeed, for the 1.2 million people who currently reside in nursing homes.

You have already heard a little bit about the staffing in nursing homes. On average, one RN for every 49 patients, giving 15 minutes of nursing care per day, is not very much. Certainly the public has come to associate nursing homes, I hope, with nursing. But one wonders whether or not we should actually call those homes something else, since very little nursing actually takes place there.

I would like to mention a number of areas that I think the bills support and which I also endorse, as well:

One of the barriers to geriatric nurse practitioners, particularly in nursing homes, are the numerous barriers to reimbursement of nursing services provided by these geriatric nurse practitioners. It is essential that we find some ways to utilize the current reimbursement structures to support some of the practices of these individuals in a number of creative ways, which can certainly include certification and recertification of the need for patient care in nursing homes, determine mandatory patient visits, make decisions regarding hospitalization, assume some of the functions of medical directors. There are many areas in which the geriatric nurse practitioner is prepared by virtue of his or her Master's education to assume some of these responsibilities.

In addition, there have been a number of very creative demonstrations that have also shown the cost effectiveness of this type of endeavor, most notably the Robert Wood Johnson Foundation Teaching Nursing Home Program, which clearly identified that the

placement of Masters-prepared nurse practitioners into nursing homes did a number of things, not the least of which was to reduce costs but also clearly to upgrade the care in the nursing home, to encourage those individuals who were giving care to improve that care, and to serve as excellent models and demonstrations for affiliations with universities whereby we could encourage others to consider a career in long-term care.

Several witnesses have identified that, to improve the quality of care provided to residents of nursing homes, we must focus on the primary reason residents are in nursing homes—that is, to receive nursing care.

Whatever strategies we can devise, either through supportive educational programs, through more creative reimbursement strategies, to bring these individuals with this level of preparation into the nursing home would be to the benefit of all of us.

I do think there are a sufficient number of demonstrations which show that there are some solutions to our problems, and I hope that we will have the courage and the political will to carry some of those out.

Thank you.

[The prepared statement of Dr. Strumpf appears in the appendix.]

Senator DURENBERGER. Thank you very much for your testimony.

Because of brevity, I think we are going to have to leave.

I rarely do this. I am not doing it "to" a witness, but just as part of a correction, at least as it applies to my State, I heard you say we should call them something other than "nursing homes," because very little nursing goes on. That may be the case in Pennsylvania, but that is not the case in Minnesota. And I know you are trying to make a point.

They may be overworked, and everything that has been said about reimbursement is true, but there is an awful lot of nursing going on in the nursing homes at least in my State. So I will take it for the point you were trying to take up.

Dr. STRUMPF. Perhaps the correction is in thinking about professional nursing care and the level of care, which I think could be improved.

Senator DURENBERGER. Thank you.

We are going to have to recess briefly until Senator Mitchell gets back.

Dean GREENLEAF. Should we stay?

Senator DURENBERGER. Oh, yes, why don't you stay. I assume he will be back shortly.

[Whereupon, at 11:28 a.m., the hearing was recessed.]

AFTER RECESS

Senator MITCHELL. I apologize for the inconvenience.

Dean Greenleaf, I wanted to ask you a question. Do you advocate the BSN Degree as a prerequisite for all nurses? And if so, do you have any concern that the requirement may discourage young women from lower income, first generation college families from entering the profession?

Dean GREENLEAF. First of all, I have to tell you that I, Nancy Greenleaf, do not advocate the baccalaureate degree as the only entry into nursing. I do see baccalaureate education as the entry into professional nursing.

Senator MITCHELL. Do you have an opinion on that, Dr. Strumpf?

Dr. STRUMPF. Yes. Certainly basic professional practice absolutely requires a baccalaureate. I don't personally think it is any more discouraging to various groups of people that that is the entry into practice than it would be for entering other types of careers. If anything, I think it is an incentive. And we do know that there are a variety of ways that people can achieve a baccalaureate education through scholarships, State universities, and so forth, and that ways can be found to support them in doing that.

Personally, I feel that the complexities of care today—whether we are talking about the elderly, my special concern, or the hospitals require that level of practitioner.

A technical level of practitioner is also appropriate to be supervised by the professional nurse, and I would certainly support that two-tiered model.

Senator MITCHELL. In your testimony you indicated that one of the problems contributing to the nursing shortage is the failure to include nurses in decisionmaking throughout the health care industry. Who is responsible for that circumstances, and what can be done about it?

Dr. STRUMPF. I think there are many competing social, historical, political and other forces which have contributed to that. I think in part one might even look to the past when the nurse's education was not as sophisticated as it is today. At this point I would suggest that the nurse has been hampered by a tradition of being closed out of a certain amount of decisionmaking, but that indeed the level of practice, the level of education, particularly when we are thinking about the baccalaureate and masters prepared nurse, truly makes it possible for him or her to participate collegially and powerfully in that decisionmaking process. I think failure to reimburse for the professional service that he or she gives has also interfered with that to some extent, because the individuals that are more likely to receive the reimbursement also control some of the decisionmaking, and that has been a problem.

Senator MITCHELL. Do you have an opinion on that, Dean Greenleaf?

Dean GREENLEAF. Yes, we do. I believe that it is no news to anyone that the health care industry has been very heavily physician-dominated and hospital management-dominated, and I do not think they have welcomed the opportunity to have nurses be on those decisionmaking panels.

Senator MITCHELL. Well, thank you both very much, and I thank all of the witnesses and all of the persons here. This has been a very informative hearing. The problem is real, it is serious. What is unclear is the extent to which federal policy can help solve the problem. As in so many other areas of life in our society, the Federal Government has a role to play, but it may not be the dominant and certainly is not the exclusive role.

Members of this subcommittee are very deeply concerned about the current nursing shortage as it affects staffing in nursing

homes, hospitals, and other health care facilities, and we are going to do our best to develop a reasonable policy, taking into account the several items of legislation that have been introduced by members of the subcommittee and others.

For your help in contributing to that effort, and for giving us your counsel and advice, we are very greatful.

Thank you all. The hearing is concluded.

[Whereupon, at 11:40 a.m., the hearing was concluded.]

APPENDIX

PREPARED STATEMENTS AND MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR JOHN H. CHAFEE

MR. CHAIRMAN, I AM PLEASED THAT YOU HAVE SCHEDULED THIS HEARING. THE NURSING SHORTAGE THREATENS EVERY PART OF THE UNITED STATES AND EVERY SEGMENT OF OUR HEALTH CARE SYSTEM. YOU HAVE INTRODUCED LEGISLATION, S. 1765, TO ALLEVIATE THIS PROBLEM AND I COMMEND YOU FOR YOUR EFFORTS.

THIS IS AN ISSUE THAT WE MUST ATTEMPT TO RESOLVE SOON. THERE IS A GREAT DEAL OF EVIDENCE TO INDICATE THAT THIS IS NOT A TEMPORARY PROBLEM, BUT RATHER ONE THAT WILL HAVE A DEVASTATING AND LONG-TERM IMPACT ON OUR HEALTH CARE SYSTEM. ENTIRE WINGS OF HOSPITALS ARE CLOSING -- EVEN WHERE THERE IS GREAT DEMAND FOR THE BEDS -- BECAUSE OF A LACK OF SKILLED NURSING STAFF. NURSING HOMES HAVE CRITICAL PROBLEMS RECRUITING NURSES TO FILL OPEN POSITIONS.

I SUSPECT THAT THERE ARE A VARIETY OF REASONS -- SOCIETAL AND ECONOMIC -- FOR THE SHORTAGE WE ARE EXPERIENCING. I LOOK FORWARD TO HEARING THE VIEWS AND SUGGESTIONS OF THE DISTINGUISHED WITNESSES THAT HAVE JOINED US TODAY. I HOPE IT WILL BE POSSIBLE FOR US TO ADDRESS THESE CRITICAL PROBLEMS SOON.

PREPARED STATEMENT OF MARGARET J. CUSHMAN

Mr. Chairman and Members of the Committee:

My name is Margaret Cushman. I am the President and Executive Director of the VNA Group, Inc. of Waterbury/Hartford, CT and serve as Chairman of the Board of Directors for the National Association for Home Care (NAHC). NAHC is the nation's largest professional organization representing the interests of home health agencies, homemaker-home health aide organziations and hospices with approximately 5,000 member organizations. On behalf of these organizations I would like to commend you for holding this hearing to focus on the nursing shortage. This an issue of crucial importance to home care providers and the beneficiaries they serve.

The nursing supply issue is not a new one. However, there are two characteristics of the current shortage that were not evident in earlier years. One characteristic is the decline in enrollments and graduations in schools of nursing. A second characteristic, equally troubling, is the widespread nature of the shortage. Unlike other shortages, which were mainly confined to hospitals, this shortage has spread to other types of health care facilities, and has already reached the community and home care settings.

For home care providers, a shortage of registered nurses, at a time when patient case load and acuity levels are increasing, along with additional pressures for and emphasis on quality assurance, is disasterous. Home care providers are now competing with other employers for a dwindling number of nurses to fill their staffing needs. During previous periods of nursing shortage, community and home health services actually benefitted from the flight of baccalaureate nurses -- in particular, from

the hospital to the community setting. It now appears that home care agencies are experiencing some of the same nurse recruitment and retention problems that have previously plagued hospitals. Experienced nurses are scarce, and nurses with community health and acute-care experience -- necessary to care for today's more acutely ill home care patient -- are even scarcer.

The outlook for community and home health services is not promising. During the previous shortage years, nurses frequently left hospital employment for positions in community health and home care agencies. Although salaries were usually $1-3,000 below those of hospitals, the nurses found that regular hours, no shift work, and weekends off were well worth the salary difference. In addition, home care agencies were more nursing oriented, generally devoid of physician domination and provided opportunities for independent decision making, autonomy and greater professional satisfaction. Nurses were able to practice nursing in a professional model. Agencies had the luxury of being able to select employees from a well-prepared pool of applicants. Community health nurses were minimally baccalaureate prepared and were usually required to have at least one year's experience in a hospital or acute care setting.

Today many of these attractions are absent from the community setting. Nurses work evenings, weekends, and even night shifts. The patient acuity level has become so heavy that their frustration is on a par with that of their colleagues who work in acute care settings. Patients who were once thought to be totally unmanageable at home are now part of their usual case load. The amount of paperwork has also dramatically increased. In order to manage their case loads and the escalating paperwork, many nurses leave the agency early in their shift, visit their patients and take their paperwork home to complete. This cannot be delegated, given the nature of requests for home care information and unduly cuts into time appropriately spent in patient care. Even after

submission of excessive paperwork, nurses are discouraged from having care unnecessarily denied, which in their professional judgements is warranted. Home care agencies have grown from small concerns to large corporates and the nurses are moved further away from the decision making processes. It appears that the problems of the hospital industry that drove nurses away are now part of home care. And, community agency salaries are often not competitive with hospital salaries.

The shrinking pool of baccalaureate nurse graduates poses real problems for community based agencies. Nurses with BSN degrees form the bulk of community health staff because the baccalaureate nursing programs have usually provided the educational and clinical experiential base for nursing practice in the more independent community setting. This is different from the hospital setting and requires an understanding of community systems, public health principles, and a fair amount of independent nursing judgements. With the advent of the DRGs and more high-tech services being provided in the home, agencies have turned increasingly to nurses with strong hospital experience. Since these nurses often lack community health experience, it takes a lot of education on the agency's part to orient them away from relying on hospitals and physicians for solutions to problems that truly involve nursing management and nursing decisionmaking in the home setting. The other side of the problem is that some experienced home care staff are overwhelmed by the acuity and high-tech needs of patients discharged "quicker and sicker" from hospitals since the advent of hospital DRG system. It is a whole new world for these nurses and some of them are not going to be able to stay in home health.

Solving the problem of the nursing shortage is not going to be easy. The problem has its roots in the profession's public image, poor employee/employer relations, and gender-dominated nature of the profession. Solutions have been posed in the past and while

some employers of nurses have implemented suggested remedies, nationally, the profession is underpaid, overworked and under valued for their contributions to health care.

The average starting salary for a staff nurse is $20,320 (AJN, 1987), which although problematic is not as troublesome as the low maximum earning for experienced nurses. The most obvious remedy is to increase wages. Nursing wages have not kept pace with salaries of other female dominated service professions such as teaching and social work.

Raising salaries for hospital nurses may not be easy with the current DRG system for Medicare. Hospital payments have not kept pace with the marketplace increases and, since nursing salaries are part of the overall routine costs, there is no adjustment for higher costs based on intensity of nursing services. Although home care and other community based services currently do not fall under the PPS program, the cost limits and the huge and still growing number of denials have operated to keep salaries down. The market basket wage and labor index used for home health cost limits is completely out of touch with rapidly escalating nursing wages. Salaries for home care agencies must be at least competitive with hospitals in order to attract nurses. This does not mean raising salaries to the same level as hospitals, rather it means raising salary scales beyond hospitals, if home care is to keep a competitive edge.

The support of nursing education programs has declined from an all-time high of $160.6 million in 1973 to $53.3 million in 1987. There is no question about the effectiveness of the Nurse Training Act in stimulating undergraduate nursing enrollments. There is a clear positive relationship between the number of dollars going to basic nursing education programs and the number of basic students in those programs.

The very reason the federal government got into support of basic nursing education stems from the fact that in 1965, it was recognized that if the Medicare program was going to be a success there would have to be sufficient numbers of nurses available to care for the patients. Thus, nurses were declared a national resource and the Nurse Training Act was born. Over the years the sense of that integral relationship beween nurses and federal health programs has been lost in the concerns of cost-containment and Medicare fraud and abuse. It is time that the federal government rethink this lost relationship and, in doing so, they may find some interesting solutions to containing costs. There is legislation, S. 1402, Nursing Shortage Reduction Act of 1987, introduced by Senator Edward Kennedy, which authorizes $5 million to study the problem of the nursing shortage and to find ways of alleviating it. NAHC applauds the recognition of the nursing shortage as a serious problem meriting legislative attention. In addition to this legislation, we should give immediate attention to issues we already know are problematical.

Conclusions

There is no question that the nation is facing a severe shortage of nurses, regardless of its source or configuration. It is further obvious that home care has been and will continue to be affected by the shortage.

The solutions for the shortage, like the reasons for the shortage, are not new. Increased wages, federal support for nursing services and nursing education, support services so that nurses may concentrate on patient care rather than clerical and errand services, and increased use of part-time nurses on the unfavorable shifts and weekends with appropriate compensation. Today's nurses want income, autonomy, respect and improved working conditions. The restructuring of the entire health care delivery system, in the long run, with the greying of America and

the impending crisis in long term care, may well be the only alternative.

It would be foolish to think that the changes needed will take place overnight. Yet there is a certain urgency for change, not only for nursing but also for the health care delivery system. Beneficiaries are already suffering fromm decreased services and access to services. If changes do not occur there will be a crisis and lives will be lost.

Thank you for giving me the opportunity to testify today. I would be pleased to answer any questions you might have.

PREPARED STATEMENT OF BARBARA CURTIS

Mr. Chairman, I am Barbara Curtis, a Member of the Board of Directors of the American Nurses' Association. I am pleased to appear today on behalf of the 188,000 members of our constituent state associations to discuss an issue of overriding concern to both our members and all of society, that of the nursing shortage. As the largest organization of registered nurses in the country, we find ourselves increasingly occupied by this crisis, and we appreciate the attention that this committee has chosen to give to the subject.

The publicity surrounding the nursing shortage has been overwhelming. Communities across the country are reporting an ever increasing shortage of nurses, and the outlook for the future indicates that this situation will only get worse. Recently conducted studies only serve to confirm the anecdotal information about the shortage of nurses. A December 1986 study conducted by the American Hospital Association revealed that 13.6 percent of hospital registered nurses (RN) jobs were vacant in 1986, compared to 6.3 percent in 1985. Two-thirds (66%) of the hospitals reported that they needed more than 60 days to fill RN vacancies in medical/surgical areas, operating rooms, emergency rooms and psychiatric nursing areas, and nearly 90 percent of the hospitals reported needing 60 days to fill intensive care nursing positions. The survey concludes that there are approximately 138,000 budgeted unfilled RN vacancies in this country. In a more recent AHA hospital survey, conducted in April 1987, 81 percent of the respondents indicated that patient acuity had increased in the prior twelve months, and that temporary agency staff were used most often to fill budgeted vacant RN positions in the ICU/CCU and medical-surgical units.

There are additional studies which focus on the shortage that we would be pleased to provide the committee. We have found, however, that the nursing shortage is accepted as a given fact, and that the discussion tends to focus on why the shortage exists, and what can be done to help alleviate it.

Causes of the Shortage

The nursing shortage stems from a variety of factors. Dramatic changes in the attitudes, values, and aspirations of young women, who formerly represented the potential recruitment pool for nursing; a demographically driven decline in the number of people entering college; massive changes in the way in which health care is delivered and paid for; and changing roles within health services sector itself all contribute to the severity of the shortage.

The most obvious among these factors, however, are the conditions in hospitals, within which 68 percent of the estimated 1.5 million working registered nurses practice, and in other institutions such as nursing homes. These conditions include modest financial rewards compared with nurses responsibilities, limited authority for the clinical practice of nursing, and little involvement in hospital management decisions regarding the provision of nursing care and essential support services. While there are numerous and complex reasons for the nursing shortage, two major causes seem to be at the root of the problem: salary and working conditions.

With respect to salary, it is not the starting salary in hospitals that causes the problem; many nurses can start in hospitals in urban and suburban areas for approximately $20,000 per year. What is unfortunate is that salaries are not commensurate with experience and responsibility, so that a nurse with ten years experience will not see her salary increase to $30,000. Compared with the income received by other health care practitioners, it becomes increasingly clear that nurses are seriously underpaid and undervalued employees. This is at the root of the nursing shortage.

Salaries and benefits for nurses must be commensurate with their level of responsibility, education, experience, and performance. Without such recognition, the nursing crisis will only be exacerbated. While many will argue that salary is not the primary reason for the shortage, we believe it is obvious that salaries must be increased in order to deal with this problem. For individuals choosing career, salary is an important consideration. Unless the

undervaluing of nursing is addressed quickly and effectively by employers, this trend will only worsen.

Regrettably, there is little the federal government can directly do about nursing salaries. The prospective payment system, in which hospitals are paid a lump sum for care for one or more diagnostic related groups, does not lend itself to changes that would put money directly into the pockets of employees. The federal government has moved in the opposite direction, and has become less and less involved with specific budgetary decision-making in hospitals. To seriously discuss a "pass through" of funds from the government through the hospital directly to the nurses runs against the tide in recent federal policy. While this idea may deserve some attention, it may not be politically viable. However, the Congress should begin to put pressure on hospital administrators to raise salaries. While we may hope that the market will cause an increase in salaries, that has not occurred during previous shortages. Hospitals and other institutions must realize that a major solution to the shortage problem is to pay a more realistic salary to their nurse employees.

One action that the federal government should discontinue is the continual cutting back of payments for health programs, particularly Medicare. Attempts by the Administration to cut payments to hospitals lessens the pool of funds available for expenses such as salaries. While we are not sure that an increase in payments to hospitals will result in a increase for the nurses, we are very sure that a decrease in funding for hospitals will ensure that no upward salary adjustments will be made. Disproportionate cuts in the Medicare program driven by budgetary policy is a sure way to worsen the nursing shortage. We will continue to work with the American Hospital Association, the Federation of American Health Systems, and others to oppose the annual budgetary assault on the Medicare program.

We believe the second major cause of the shortage involves the environment in which nurses must work. Working conditions are quite difficult, with nurses often treated poorly. Hospital administrators, physicians, and nurses have an obligation to establish a suitable environment for nursing practice. Nursing

should be involved in policy development and decision-making throughout the organization, a situation which rarely occurs at present. There must be a greater emphasis on respect and recognition of the value of nurses' work. Studies have shown that effective nursing practice is found where conditions of employment foster professional growth and development. Approaches such as flexible work hours, appropriate staffing patterns, career advancement patterns, and recognition for achievement should be explored. Nurses must have a greater say over their own practice, and be more involved in overall patient care.

Again, the solution to the goal of enhancing the work environment for nurses does not lie entirely with the federal government. We ask that the committee send a clear signal to the hospital and nursing home industries that such a change is essential if the crisis is to be rectified. Institutional providers must begin to understand that the federal government is keeping a close check on their efforts to combat the nursing shortage. Failures to enhance salaries and working conditions may need to be met by Congressional action, such as the promise of increased regulation to correct such actions.

Impact on the Elderly

The most troublesome aspect of the nursing shortage is the impact on the nursing care needs of people 65 and over, the single largest age group now occupying acute care hospital beds. Today's hospital patient is sicker and needs more intensive nursing care. Any shortage of nursing staff will place the elderly at increased risk. We can foresee a situation where our increasingly elderly population faces a decreasing pool of qualified nurses. This can only hurt quality of care.

The impact on post-acute care is equally disturbing as we have shortened hospital stays, we have lost valuable nursing services. This is where nurses prepare patients for what will happen to them, teach them and their families about medications and procedures, and helping patients with the anxiety over their illness. It is also the time that nurses work with families and other health care providers in developing discharge plans and ensure that patients

receive the care they need in nursing homes or in their homes. Nurses are now expected to cover the whole spectrum of services needed got a duration of illness including both acute and post-acute care. Consequently, the shortage adversely impacts the elderly in all phases of their care.

Nursing Home

While we have focused on the problems related to hospitals, it is important to note that the situation is far worse in nursing homes. Salaries are 15-25% below those in hospitals, and working conditions are more difficult. The nursing home industry has refused to provide adequate compensation for their employees, and have fought against federal regulation of minimum staffing requirements. In our view, the shortage in nursing homes can be positively impacted by the federal government by mandating increased nurse staffing. Only when forced by the federal government will nursing homes hire adequate staff. Such a requirement will also force the industry to pay a competitive wage in order to attract the required personnel. In this industry, requiring an increase in staffing will result in an alleviation of the shortage, as the industry will have to raise wages, and that will attract the nurses.

Therefore, we commend the chairman for his efforts to increase RN staffing in nursing homes through the inclusion in reconciliation of his legislation, S. 1108. However, we ask that, in conference, the committee accept the House Energy and Commerce Committee provision which requires an RN for 16 hours per day in facilities of 90 beds or more, and 8 hours in facilities of 90 beds or less. This provision would ensure a higher level of quality care in nursing homes, and will increase recognition of nurses in such facilities.

Comments on S. 1765

We would also like to commend the Chairman for his introduction of S. 1765. The mere introduction of this legislation will help focus congressional attention on the issue. In our view, such efforts can only have a positive impact on the debate surrounding the nursing shortage crisis.

Section 2 of the bill establishes a demonstration authority for community nursing organizations. This provision has been incorporated into the Finance Committee's reconciliation package, and we are quite pleased by that action. By allowing nurses to establish these organizations and receive payment for their services, which they do not receive under current law, we believe that the number of nurses willing to remain in the profession will greatly increase. Medicare payment policy, which refuses to recognize nurses as reimburseable providers, is another major reason for the shortage. The willingness of the federal government to recognize and pay for the services of nurses will greatly enhance the attractiveness of nursing. We would ask, however, that the committee accept the House Energy and Commerce Committee provision which is a complete authority for the establishment of community nursing organizations rather than a demonstration project.

Section 3 of the bill will allow nurse practitioners and clinical nurse specialists to certify and recertify patients in nursing homes. As geriatrics is a major area of shortage, this provision would make far more attractive nursing practice in nursing homes. Allowing nurses to certify the need for care, and paying them for that service, will provide nurses with another attractive career option. This provision will not increase health care costs, will increase access to care in facilities, and will provide an incentive for nurses to enter the field of geriatrics. We commend the chairman for inclusion of this provision, and we understand that it may be offered as a floor amendment when the Senate debates the reconciliation legislation.

Section 1 of S. 1765 envisions an expansion of the graduate medical education pass-through for the clinical training of nurses. Under current law, only programs supported and operated by hospitals are eligible for payment under this program. We believe this to be an artificial limitation that ignores recent trends in nursing education.

Increasingly, nurses are receiving their education in collegiate schools of nursing. Permitting additional institutions to develop clinical education rotations for nurses in cooperation with accreditated nursing education programs

would benefit not only the institution through the patient care provided by student nurses, but also may encourage nurses to practice in such institutions after their education is completed. Such a program would also help to bring advancements in nursing practice more rapidly to the bedside through the collaboration of faculty from the educational program and nurses in clinical practice in hospitals.

Regrettably, an expansion of the GME authority to encompass all nursing education programs would be expensive, and is unlikely in the current political environment. However, limiting the number of students based upon a variety of factors, such as location (urban/rural), specialty (critical care, operating room), or type of degree (graduate), could limit the financial burden of the program. We would like to work with the committee to formulate such a proposal.

Conclusion

Of the numerous studies and recommendations which address the nursing shortage, a recent study by the American Academy of Nursing and the American Hospital Association articulated the following reasons for the shortage: financial rewards that are not commensurate with responsibility; opportunities for upward mobility are lacking; nurses have insufficient authority and autonomy; work demands are increasing because of rising severity of illness; and nurses do not participate in management decisions regarding practice standards and support services.

Any proposed solution to the shortage crisis should use these finding as a blueprint. Unless these problems are addressed adequately, we will not have a solution to the problem. This is not a small problem that can be resolved with a quick solution; it requires some fundamental changes in the way in which our health care system currently functions. We hope that these hearings can serve as a beginning in a nationwide effort to combat the nursing shortage. We again commend the chairman and the committee for their willingness to tackle this elusive and troubling issue. We look forward to working with you to help alleviate the nursing shortage crisis.

PREPARED STATEMENT OF SENATOR DAVID DURENBERGER

I'm very pleased that the Senate Finance Health Subcommittee, led by my distinguished colleague Senator Mitchell, is turning its attention to the growing need for nurses in this country. I would like to commend Senator Mitchell for calling this hearing to address this serious problem. I hope that we can begin to develop long-term, creative, cost-effective solutions.

The number of nurses educated in schools of nursing has grown dramatically in the past 30 years, but our unmet need for nurses is still increasing rather than decreasing. This problem is not due to any past failures to train or recruit nurses. Rather, the current shortage reflects a greatly increased demand even more than a declining supply.

There are several reasons for this higher demand. Because of changes in medical practice, hospitalized patients are sicker and require higher levels of professional care than they have in the past. Wages and other incentives for nurses have not risen with the speed or magnitude seen in other labor markets. Finally, the specialized abilities of registered nurses are not fully utilized.

Under current management practices, these professionals with increasingly sophisticated education and technical training are often required to perform many non-clinical tasks, which inhibit their ability to provide high-quality, cost-effective patient care. In the process, resources are wasted and nurses have low levels of job satisfaction. These facts are well-documented in an excellent article by Dr. Linda Aiken and Connie Mullinix entitled "The Nurse Shortage: Myth or Reality", in the New England Journal of Medicine, which, Mr. Chairman, I would like to submit for the record.

To solve these problems, I believe that a radically different approach is needed, one that recognizes the vastly increased options that women today have to choose other careers. Nursing must come into the 1990's and beyond if it is to continue to attract the top flight women (and men) who now have many other choices. Health care managers and nursing, which has long been one of the great opportunities for dedicated and talented women, also need to prepare for the future. The future will be better only if the levels of professionalism and autonomy are high and the practice environment is challenging and rewarding. The world for women has changed and I am proud to have helped accelerate that change by pushing hard for economic and other equity for women in legislation since I first came to the Senate, most recently with S. 1309, "The Economic Equity Act of 1987".

For these reasons, I will today be introducing the Medicare Nursing Practice and Patient Care Improvement Act of 1987. By funding projects to demonstrate and evaluate innovative nursing practice models, this bill will encourage hospitals and nursing homes to utilize registered nurses as patient care managers, increase nurses' roles in facility administration, develop career progression opportunities for nurses, and improve working conditions to retain and attract the highest quality staff.

My own state of Minnesota has had excellent experience in using professional nurses as case managers. Currently, all 87 counties in Minnesota are using RNs as case managers for Medicare beneficiaries. These nurses are helping seniors and their families to make informed decisions about their care, helping people stay out of nursing homes, promoting independence, and helping to ensure high-quality, cost-effective health care for senior citizens. By translating this experience into the hospital and long-term care setting, we will improve job satisfaction and foster recruitment and retention.

We in the Congress know from the past that quick-fixes to nursing shortages have only served to create long-term problems. Our challenge today, then, is to find solutions not only for the present, but also for future generations.

THE NEW ENGLAND JOURNAL OF MEDICINE Sept. 3, 198

SPECIAL REPORT

THE NURSE SHORTAGE

Myth or Reality?

THE proportion of vacant positions for registered nurses in hospitals doubled between September 1985 and December 1986,[1] reaching the levels of the last national nursing shortage of 1979. Current reports of vacancies are perplexing in the light of the size of the nation's supply of nurses. The output of nurses has doubled over the past 30 years, greatly exceeding the population growth, and licensed registered nurses now number 2.1 million. Between 1977 and 1984 alone, the number of employed nurses increased by 55 percent, as compared with an 8 percent growth in population.[2] Intuitively, it would seem that an increased number of nurses would be the solution, but the problem persists nevertheless.

The reported shortage of hospital nurses exists in the midst of a substantial reduction in hospital inpatient capacity nationally. The demand for acute inpatient care in general hospitals has fallen, resulting in 50 million fewer inpatient days in 1986 than in 1981. Since 1983, hospitals have closed more than 40,000 beds, and average hospital occupancy rates dropped

to 63.4 percent in 1986.[3] Enrollments in nursing schools have also decreased markedly, raising the possibility that fewer nurses than anticipated will be available in the future.

There is now a contentious debate about whether a shortage of hospital nurses truly exists and about its causes. In 1981, the Institute of Medicine was commissioned by Congress to reconcile the evidence of an increased supply of nurses with continued reported shortages. The study concluded that the national supply of generalist nurses was adequate for the present and short-term future.[4] Cyclical vacancies in positions for hospital nurses were attributed primarily to local labor-market conditions, although a shortage of nurses in certain specialties was noted. Recommendations were made to the hospital industry on the need to restructure nursing roles and develop improved financial rewards and opportunities for career advancement in clinical care.[5] The National Commission on Nursing made remarkably similar recommendations in 1983.[6] But in 1986, the American Hospital Association was again reporting that high vacancy rates in positions for nurses were disrupting hospital care,[1] whereas the U.S. Department of Health and Human Services again concluded that the national supply of nurses was in balance with the demand.[7]

Employment Patterns of Nurses

The shortage of nurses is measured by the hospital industry as vacant budgeted full-time-equivalent positions for registered nurses. Vacancy rates, however, are not an objective measure of the need for bedside nurses. Moreover, the number of budgeted positions for nurses reflects a number of factors, including budget constraints as well as local wage rates. Despite these limitations, we have chosen to analyze vacancy rates because they are used by the industry to reflect the changing supply of nurses.

There are several commonly held but erroneous beliefs about nurses' work patterns. One misconception is that nurses have left nursing in large numbers and are either inactive or working at jobs outside health care. In contrast, nurses have one of the highest rates of participation in the labor force among workers in predominantly female occupations. Almost 80 percent of registered nurses are actively employed[2] either full-time or part-time, as compared with 54 percent of all American women. Not much is known about those who do not renew their licenses and, therefore, are not counted in the population of registered nurses. But less than 6 percent of registered nurses are employed in other occupations and are not seeking a position in nursing.[2] Given the responsibilities of women for child rearing and other domestic concerns, an employment rate of 80 percent may be almost as high as can be expected. Thus, it is unlikely that unemployed nurses represent a large potential resource for hospital employment. However, nursing is somewhat unusual in that 27 percent of the total pool of registered nurses work part-time. Clearly, a change in the number of hours worked by more than 500,000 part-time registered nurses could substantially affect the supply of full-time-equivalent nurses.

Some observers have suggested that the shortage of nurses in hospitals may be due to the increased demand for nurses in ambulatory settings and new administrative positions in health care. However, hospitals' share of the ever-growing pool of nurses has not changed substantially since 1960. Sixty-eight percent of all employed nurses work in hospitals.[2] Hospitals have dramatically increased the number of nurses they employ in the aggregate and in relation to numbers of patients, even when the recent increase in outpatient visits is taken into account. In fact, hospitals are employing more registered nurses than ever before and are even replacing non-nurses with nurses — just the opposite of what would be expected during an actual shortage of nurses.

In response to reduced numbers of inpatients, hospitals employed 133,376 fewer full-time-equivalent workers in 1986 than in 1983.[3] In contrast, the number of full-time-equivalent nurses increased by 37,500 during the same period.[8,9] A substantial increase in the ratio of nurses to patients resulted. In 1972, hospitals employed 50 nurses per 100 patients (average adjusted daily census); by 1986, the figure had increased to 91 nurses per 100 — an 82 percent expansion (Fig. 1). Aides and licensed practical nurses were replaced by registered nurses. In 1968, registered nurses accounted for only 33 percent of hospitals' total nursing-service personnel; by 1986, registered nurses accounted for 58 percent.

The Changing Demand for Nurses

The rapidity with which the current shortage developed suggests that increased vacancy rates must be due to a changing demand for nurses, not to a declining supply. There are three primary explanations for the recent increase in the demand for hospital nurses. First, hospitalized patients are sicker and require more care than in years past, on average, because of the reduction in discretionary admissions and the shorter average length of stay. However, there is no basis to suggest that the average condition of hospitalized patients changed dramatically enough between 1982 and 1986 to require a 26 percent increase in the ratio of registered nurses to patients. Although the changing case mix may provide a partial explanation for the increased demand for nurses, it cannot be the only explanation.

A second explanation for the recent increase in vacancy rates is related to changing budget constraints in hospitals. When vacancy rates were at an all-time low of 3.7 percent in 1984, the Medicare Prospective Payment System was just being implemented and fears of severe hospital-budget limits were widespread. As a result, some budgeted positions were

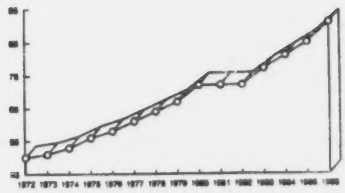


Figure 1. Number of Hospital Registered Nurses Employed per 100 Patients (Average Adjusted Daily Patient Census), 1972–1986.

Data are from *Hospital Statistics*.[9]

eliminated. Unexpectedly high operating margins, however, provided the opportunity for hospitals to budget for more nursing positions.

A third explanation is related to changes in nurses' relative wages. In most labor shortages, wages are adjusted and other incentives are developed to attract additional workers. These market adjustments fail to occur in nursing with the rapidity or magnitude seen in other labor markets. Labor economists have described nursing as a "captured" labor market.[10,11] In any given community, a small number of hospitals employ most of the local nurses — a phenomenon known as oligopsony in labor economics. Employers offering nurses jobs with weekday hours usually have no trouble employing nurses and thus do not compete with other employers on the basis of salary. There is no demand for nurses outside the health care field that is sufficient to create competitive pressures on the hospital industry, as there is, for example, for computer programmers. Moreover, hospital administrators tend to assume that there is a finite number of nurses in any given community, and that wage competition among hospitals will be costly and will not resolve community shortages. The majority of nurses, if they want to work, must accept the terms offered by hospitals.

Registered nurses are versatile employees in a hospital context.[12,13] They can provide all the services for which hospitals sometimes employ nurses' aides and licensed practical nurses, and they can also often perform a wide range of other functions, including those assigned at other times to secretarial and clerical personnel, laboratory technicians, pharmacists, physical therapists, and social workers. Nurses substitute for physicians under some circumstances, and commonly assume hospital management roles after regular work hours. Thus, when nurses' relative wages are low as compared with other workers', it is advantageous for hospitals to employ them in greater numbers and in lieu of other kinds of workers. Even if nurses' wages are 20 to 30 percent higher than those of licensed practical nurses or secretaries, it may still be more economical to hire nurses, because they require little supervision and can assume responsibility for a wide range of duties. The increased demand for nurses created by low relative wages can lead to shortages in some geographic locations, in specialty units, and on undesirable evening, night, and weekend hours.

The relative-wage theory is supported by data spanning several decades[14,15] (Fig. 2). From 1946 to 1966, for example, the increases in nurses' wages lagged behind those in comparable women's occupations. Nurses' wages over the period increased by 53 percent, whereas teachers' salaries increased by 100 percent and female professional and technical workers' salaries increased by 73 percent. In the early 1960s, more than one in five budgeted positions for nurses were vacant. There was great concern at the time that the increased demand for hospital care accompanying the introduction of Medicare and Medicaid would exacerbate the shortage of nurses. But these new programs were accompanied by substantial wage increases for nurses. Employment rates among nurses increased substantially after these wage increases, as did enrollments in nursing schools. The proportion of vacant budgeted positions for nurses in hospitals dropped from 23 percent in 1961 to 9 percent by 1971. But, after hospital wage and price controls in 1971 and state rate setting and the voluntary hospital cost-containment effort a few years later, nurses' wages declined relative to other groups' and the proportion of vacant positions for nurses in hospitals increased again, leading to the shortage of 1979. There was a wage response to the 1979 shortage; nurses' wages rose an average of 13 percent annually in both 1980 and 1981. By 1984, the proportion of vacancies had reached a low of 3.7 percent.

The substantial wage increases received by nurses in 1980 and 1981 did not continue subsequently, and by the time the new Medicare prospective payment system was implemented, nurses' wages had been

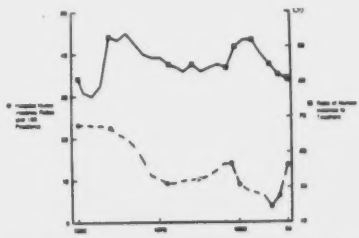


Figure 2. Hospital-Nurse Vacancy Rates per 100 Budgeted Positions and Ratio of Nurses' Incomes to Those of Teachers.

Data are from references 10 and 16 through 21.

eroded. Hospital nurses have received only modest wage increases since 1982. By 1985, average salaries for teachers were 19 percent higher than those for nurses, and average salaries for all female professional and technical workers were 10 percent higher. Despite all the publicity about the shortage of hospital nurses, nurses' wages increased only 4 percent in 1986.[18]

Declining Nursing School Enrollments

Since 1985, enrollments in nursing schools have dropped by 20 percent[22] (and National League for Nursing, unpublished data). The number of new nurses graduating annually is predicted to fall from a high of 82,700 in 1985 to 68,700 or lower by 1995.[7] All types of nursing programs have had declining enrollments: associate-degree programs have had a decline of 19 percent, and baccalaureate programs 12 percent (National League for Nursing, unpublished data). Enrollments in three-year hospital diploma programs have been declining for more than two decades and now account for only 14 percent of graduates annually (Fig. 3).

The country's demographic profile is partly responsible for declining enrollments because of the smaller size of 18-year-old cohorts in recent years. However, interest in nursing as a career has fallen precipitously among college freshmen in both community colleges and four-year institutions. The University of California, Los Angeles, national survey of first-time college freshmen indicated a 50 percent decline since 1974 in the proportion of full-time women students planning to pursue nursing careers, in contrast to an almost threefold increase in the proportion interested in careers in business[23] (Fig. 4). Moreover, the College Board recently released data indicating that the SAT scores of high-school students interested in nursing careers were well below the national average for college-bound students, and that the SAT gap between prospective nurses and non-nurses was widening over time.[24]

There are many reasons for the declining interest in nursing. Whereas starting salaries of nurses are now comparable to those of other college graduates, the average maximum salary for nurses is only $7,000 higher than the average starting salary.[18] Since more women are choosing to work continuously in the labor force, the low raises discourage them from choosing a career in nursing. Moreover, employers do not offer substantial differences in salary in return for advanced education in nursing. Thus, the economic return on a baccalaureate degree in nursing is poor as compared with the return in alternative fields. Women today have many more career options than they had in years past. Most other careers offer comparable or higher economic rewards and do not require night and weekend work — a notable disadvantage of nursing.

Recommendations for Change

A number of issues deserve careful reconsideration and experimentation. First, public-policy makers

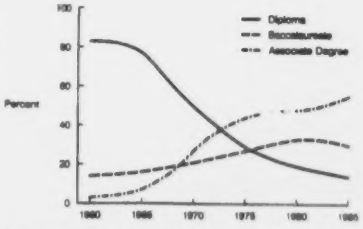


Figure 3. Percentages of Graduates of Nursing Schools in Various Types of Programs, 1960–1985.
Data are from *Nursing Data Review*.[22]

must recognize that hospital rate setting can induce labor shortages by artificially depressing wages in occupations like nursing, in which hospitals are the dominant employers. In the short term, depressed wages will increase the demand for nurses, because they can substitute for other personnel, and result in acute spot shortages and high vacancy rates. Over the long term, recruitment to nursing will be seriously eroded by the absence of an adequate salary range that rewards skill and experience.

Second, one of the most unattractive aspects of nursing is the requirement of night and weekend work. With sicker patients, hospitals now need many more nurses on these unpopular shifts than they needed in the past, when it was not unusual to have a single nurse covering a unit at night. Most women want to work regular daytime hours and will even choose less interesting, less skilled, and worse-paying jobs to accomplish this. Preference for day work explains why vacancy rates are low in ambulatory care despite low-

Figure 4. Career Preferences among Full-Time College Freshman Women, 1966–1985.
Data are from Astin et al.[23]

er average salaries. Other industries that operate on a 24-hour basis offer substantial differences in wages for evening, night, and weekend work in order to attract sufficient voluntary staff coverage. Hospitals offer only small differences and try to make shift rotation a requirement of employment. Curiously, most of the innovations hospitals have adopted to reduce vacancies during unpopular shifts actually encourage nurses to work fewer hours. For example, some hospitals pay nurses a full-time salary to work two 12-hour weekend shifts (24 hours per week) but will not pay full-time nurses equivalent hourly rates for unpopular shifts. In view of all the expenses associated with continued high vacancy rates, increasing marginal wage rates to fill vacancies on unpopular assignments might not be as costly as is commonly assumed.

Third, the work requirements of nurses and other personnel in hospitals should be restructured. The ratio of support personnel to professionals is substantially lower in the hospital industry than in other industries. Given the complexities of operating busy hospital inpatient units, there is an astounding absence of secretaries, administrative assistants, and mid-level non-nurse managers. Moreover, the computerization of hospitals has lagged far behind that of other industries. Nurses are currently performing many nonclinical, administrative, and management functions in hospitals. Fewer better-paid and better-educated nurses in combination with an improved nonclinical support staff might yield better care without substantial increases in operating costs.

Fourth, hospital management should introduce incentives to encourage experienced nurses to remain in clinical care. A differentiated wage structure that recognizes experience and advanced education is critical. Employment benefits such as pensions, tuition support, and sabbaticals could be used much more effectively to develop "loyalty" and thus reduce costly staff turnover.

Fifth, physicians should take leadership roles in the development of more effective collaborative models of practice with nurses in hospitals. Much of the dissatisfaction of nurses with hospital practice is related to the absence of satisfying professional relationships with physicians. Many nurses choose administration over clinical practice in an effort to obtain greater status in their interactions with physicians. More effective nurse–physician collaboration in clinical care activities would improve the professional satisfaction of both groups and contribute to improved patient outcomes as well.[25]

Conclusions

The evidence suggests that under current market conditions in many local communities, the demand for nurses is greater than the supply. Regardless of the reasons for this imbalance, there is only a limited number of possible solutions. Expansion of nursing-school enrollments to increase the national supply of nurses might eventually solve the vacancy problem but is unlikely to occur, given demographic trends and the declining interest of young people in nursing careers. Recruiting inactive nurses into the work force is also not a promising solution because employment rates are already high among nurses and may have reached a ceiling. Expanding the number of nurses trained abroad is an expedient option but one that might create more problems, in terms of quality of care, than it would solve. The development of incentives to induce part-time nurses to work more hours is a promising option that should be pursued. Finally, if all the above methods to increase the supply of nurses still do not eliminate disruptive vacancies, restructuring hospitals to make more appropriate use of the special expertise of nurses is a difficult but obvious alternative.

None of these recommendations are new; they have been advocated consistently by every panel studying nursing shortages. Implementation, in contrast, has been slow, despite encouraging evidence from the few hospitals that are making the suggested changes.[26] The fact is that nursing shortages are a consequence of complacent management and the reluctance of administrators to reexamine traditional practices. In the light of the attitudes of young women and their changing aspirations, what is now an artificially created shortage may become a critical problem in the future. Nurses are an essential resource for hospitals and the nation's health. Addressing their needs and aspirations realistically and examining their work conditions meaningfully are prerequisites for high-quality patient care now and in the future.

Linda H. Aiken, R.N., Ph.D.
Connie Flynt Mullinix, R.N., M.P.H., M.B.A.

Robert Wood Johnson Foundation
Princeton, NJ 08540

This report is a modification of the Distinguished Scholar Lecture inaugurating the Center for the Advancement of Nursing Practice, Beth Israel Hospital, Boston, November 21, 1986. The ideas expressed are those of the authors and no endorsement by The Robert Wood Johnson Foundation is intended or should be inferred. Address reprint requests to Dr. Aiken at Box 2316, Princeton, NJ 08540.

References

1. Curran CR, Minnick A, Moss J. Who needs nurses? Am J Nurs 1987; 87:644-7.
2. Department of Health and Human Services. The registered nurse population, 1984. Springfield, Va.: National Technical Information Service, 1986 (DHHS publication no. (HRP) 0906938.)
3. Economic trends. Vol. 3, No. 1. Chicago: American Hospital Association, 1987.
4. Institute of Medicine, National Research Council. Nursing and nursing education: public policies and private actions. Washington, D.C.: National Academy Press, 1983.
5. Aiken LH. Nursing's future: public policies, private actions. Am J Nurs 1983; 83:1440-4.
6. National Commission on Nursing. Summary report and recommendations. Chicago: Hospital Research and Educational Trust, 1983.
7. Department of Health and Human Services. Fifth report to the president and congress on the status of health personnel: report on nursing. Springfield, Va.: National Technical Information Service, 1986 (DHHS publication no. (HRP) 0906604.)
8. Hospital statistics. Chicago: American Hospital Association, 1983.
9. Hospital statistics. Chicago: American Hospital Association, 1986.

10. Yett DE. An economic analysis of the nurse shortage. Lexington, Mass.: Lexington Books, 1975.
11. Feldstein PJ. Health care economics. New York: John Wiley, 1979.
12. Aiken LH. Nursing priorities for the 1980's: hospitals and nursing homes. Am J Nurs 1981; 81:324-30.
13. Mechanic D, Aiken LH. A cooperative agenda for medicine and nursing. N Engl J Med 1982; 307:747-50.
14. Aiken LH, Blendon RJ, Rogers DE. The shortage of hospital nurses: a new perspective. Ann Intern Med 1981; 95:365-73.
15. Aiken LH. The nurse labor market. Health Aff (Millwood) 1982; 1:30-40.
16. Mullner R, Byre CS, Whitehead S. Hospital vacancies. Am J Nurs 1982; 82:592-4.
17. Report of the 1986 Hospital Nursing Supply Survey. Chicago: American Hospital Association, 1986.
18. National Survey of Hospital and Medical School Salaries. Galveston, Tex.: University of Texas Medical Branch at Galveston, 1987.
19. Money, Income, and Poverty Status of Families and Persons in the U.S.: 1979-1986. Current Population Reports. Washington, D.C.: Bureau of the Census. (Series P-60.)
20. National Center for Education Statistics. Digest of education statistics, 1979-1987. Washington, D.C.: Department of Education, 1987.
21. American Hospital Association. Nurse vacancy rates: analysis from the 1982-1985 annual survey. Chicago: American Hospital Association, 1986.
22. Nursing data review: 1985-1986. New York: National League for Nursing, 1986.
23. Astin AW, Green KC, Korn WS. The American freshman: twenty year trends, 1966-1985. Los Angeles: American Council on Education/UCLA, 1986.
24. Feinberg L. Area nursing schools seek cure for decreasing enrollment. Washington Post, August 11, 1986.
25. Knaus WA, Draper EA, Wagner DP, Zimmerman JE. An evaluation of outcome from intensive care in major medical centers. Ann Intern Med 1986; 104:410-8.
26. Magnet hospitals: attraction and retention of professional nurses. Kansas City, Mo.: American Academy of Nursing, 1983.

HEALTH POLICY REPORT

PROBLEMS FACING THE NURSING PROFESSION

JOHN K. IGLEHART

THE nation's hospitals, many of which are struggling in a new environment of prospective payment, reduced demand for their inpatient services, and increasing competition from physicians in ambulatory settings, have a new problem to confront: a shortage of registered nurses, the largest single professional discipline of the medical care delivery system. With a suddenness that surprised even long-time observers of cyclic shortages of nurses, the demand for registered nurses is outstripping the supply, and the factors that add up to this shortage suggest that there is no quick solution to the problem.

The nursing shortage stems from a variety of factors, only some of which can be controlled by hospitals and, in some instances, their medical staffs. The most obvious among them are the conditions in hospitals under which most nurses work — small financial rewards as compared with their responsibilities, limited autonomy in clinical situations, and little involvement in hospital management decisions regarding standards of practice and support services. Largely as a consequence of these factors and increasing opportunities in a variety of ambulatory settings outside hospitals, the turnover rate of nurses in the average hospital was 18 percent last year, according to the National Association of Health Care Recruitment. Hospitals are also employing about 25 percent more nurses now than they did before implementation of Medicare's new payment approach.

Broader considerations are also hampering the ability of hospitals to recruit registered nurses. Many women are now pursuing more lucrative careers in business, engineering, law, medicine, and science, few of which require night and weekend work or rotating shifts. Reflecting this decline in interest, annual surveys conducted between 1974 and 1986 by the American Council on Education and the UCLA Cooperative Institution Research Program showed a 50 percent drop in the proportion of first-time, full-time freshman women in all kinds of institutions of higher learning who planned to pursue careers in nursing. Indeed, by 1986 more freshman women expressed a preference for medicine than for nursing as a career. Finally, with a static birth rate, the number of 18-year-olds enrolling in higher education is decreasing and will continue to decline until 1995.

The latest nursing shortage is occurring during a turmoil in the profession itself. Throughout its history, nursing has struggled with definitional issues. Embedded firmly in traditional mothering roles (97 percent of nurses are women), nursing has found it difficult to make transitions into the professional and scientific fields.[1] For the past two decades, nursing interests have been at odds over these issues, particularly in relation to educational preparation. Students prepare for state registered nurse examinations through any one of three kinds of programs that last for two, three, or four years. Because the educational programs lead to the same licensing examination, hospitals do not differentiate between new registered nurses when they are hired, thus lessening the value of a baccalaureate degree. The American Nurses Association (ANA) has sought since 1965 to make a bachelor's degree the minimum educational requirement for licensure of registered nurses, but its campaign has met with only limited success.

The nursing profession has also sought to shed its historic image of being strictly beholden to medicine, by promoting the establishment of nurses in independent practice and by seeking direct reimbursement for services from third-party payers. These pursuits have produced some changes in the relationship that nurses maintain with patients and other providers of health care, but generally these changes have come only after protracted battles with organized medicine. Legislatively, the most recent conflict in relation to nursing's pursuit of independent practice was provoked by a bill (H.R. 1161) introduced by Representative Richard A. Gephardt (D-Mo.) and 70 other House sponsors that would authorize the Health Care Financing Administration to contract with nursing service organizations to provide all Medicare Part B benefits, except physician, x-ray, and laboratory serv-

ices, on a prepaid, capitated basis. The American Medical Association (AMA) is strongly opposed to the measure.

Organized medicine's opposition to efforts by the nursing profession to broaden its clinical purview has also taken another recent form: withdrawal from participation in the National Commission on Nursing Implementation Project, which is seeking to advance the profession's educational and political agenda. Dr. James H. Sammons, the AMA's executive vice president, said in a letter on February 27 to the Commission's project director, Vivien DeBack, "withdrawal at this time is in the best interests of medicine and nursing."

The basis for the AMA's action, Sammons said in a telephone interview, was that "damn document," a reference to a recent publication of the ANA entitled, "New Organizational Models and Financial Arrangements for Nursing Services." The national commission, funded for three years by the W.K. Kellogg Foundation, is composed mostly of leaders in nursing, but also includes representatives of big business, commercial insurance, consumers, and hospitals. Its mission is to implement the recommendations of the National Commission on Nursing, an advisory body created by the American Hospital Association during the previous nursing shortage in the early 1980s. The commission had no direct connection with preparation of the ANA document. Nevertheless, the AMA considered the commission's agenda to be akin to that articulated by the nursing association's publication and thus threatening to the AMA's view of the best interests of medicine.

Another reflection of the ongoing conflict between nurses and physicians is the intensifying struggle that engages the American Association of Nurse Anesthetists and the American Society of Anesthesiologists. The American Association of Nurse Anesthetists is persuaded that a series of developments in recent years indicate that the American Society of Anesthesiologists and its members are actively attempting to eliminate the position of certified registered-nurse anesthetist and gain full control of the practice of anesthesia. One of these developments is the promulgation of new standards for surgery and anesthesia by the Joint Commission on Accreditation of Hospitals (JCAH), which the American Association of Nurse Anesthetists believes will further restrict the hospital practices of nurse anesthetists. The American Association of Nurse Anesthetists has retained a Washington law firm (Arnold and Porter), well regarded for its expertise in antitrust issues, to study the possibility of bringing suit against the JCAH in an effort to alter the new standards, which take effect on January 1, 1988. Another development of concern to the Association is the closure since 1981 of about one third of the nation's programs for nurse anesthetists, reducing the number of their graduates by almost half since then.

In this report, I will discuss some of the main issues that currently engage the nursing profession, including the shortage of hospital nurses and the bleak outlook for attracting more people into the field, the status of the longstanding disagreement within nursing over the educational preparation of registered nurses, and current federal policies in relation to the field. The Reagan administration has been partially successful in its efforts to eliminate all forms of federal support for nursing education, but Congress has refused to abandon the profession in this regard. In fiscal 1973, the year in which Congress appropriated the most support, the Department of Health and Human Services (DHHS) spent $160.6 million for this purpose. Congress appropriated $72.3 million for nursing programs in fiscal 1987, including $19 million for a new nursing-research center at the National Institutes of Health.

Historically, the supply of nurses in the United States has fluctuated in relation to the demand. The current shortage is particularly vexing because the demand for inpatient care has declined dramatically. There were 46.7 million fewer inpatient hospital days in 1986 than in 1980, the average hospital occupancy rate dropped from 75.9 percent to 63.4 percent during the same period, and the number of hospital employees fell appreciably as well, according to the American Hospital Association. In addition, a total of 414 hospitals closed in the United States between 1980 and 1986, accounting for 56,628 beds.[2] Given the reduced demand for services and the labor-intensive nature of hospital care, one could reasonably anticipate layoffs of nurses or at least an adequate supply of nurses by 1986.

Instead, although the national pool of employed nurses is at an all-time high of 1.5 million (68 percent of whom work in hospitals) and hospital closures continue, the American Hospital Association is reporting another nursing shortage, one that its vice president for health care management and patient services, Connie Curran, insisted in an interview is different and more serious than shortages of the past. "Not only is this the first time a nursing shortage has cut across all categories of nurses and all regions of the country, but it is occurring despite the fact that demand for inpatient hospital care is declining."

The American Hospital Association bases its documentation for a shortage of nurses on a survey conducted by one of its members — the American Organization for Nurse Executives. This survey of 1000 hospitals found that the rate of vacant positions for registered nurses had more than doubled between 1985 and 1986, rising from 6.5 percent to 13.6 percent. Only 17 percent of the hospitals surveyed had no vacancies for registered nurses in 1986, as compared with 35 percent of hospitals reporting the year before. Large hospitals found it more difficult to recruit nurses in 1986 than did small hospitals. Although hospitals in all regions had some degree of difficulty in recruiting nurses, the problem was worst in the Middle Atlantic,

Pacific, and East–North Central regions. Hospitals reported that it was particularly difficult to fill positions in demanding clinical areas, such as medical–surgical care, intensive care, emergency and operating room care, and psychiatric care.

The American Hospital Association attributes the nursing shortage to a variety of factors, including those cited above and also the advent of Medicare's prospective payment system, the proliferation of alternative health delivery plans that provide nurses with new career opportunities in the ambulatory setting, a sharp drop in nursing school enrollments, what Curran characterizes as the consistently negative portrayal of nurses by the media ("nurses in the media are seen as 'go-fers' for doctors or promiscuous sex objects, but not as the caring responsible professionals they really are"), and the disarray in the educational preparation of nurses. "The culture of hospitals has been traumatized in recent years and this disquiet has affected nurses no less than physicians or hospital administrators," Curran said.

The economic incentives of prospective payment influence hospitals and physicians to provide care on an outpatient basis whenever possible, and to make inpatient stays conform to the limits established by diagnostic-related groupings. One of the consequences of this economic equation is that the average hospital patient is more severely ill than in the past, because less serious cases are treated on an outpatient basis. The increasing severity of patient illness, which has been documented by the Prospective Payment Assessment Commission,[3] and the subsequent rising demand for nursing care, is reflected by the change in the ratio of nurses to patients in hospitals. The ratio rose from 50 nurses for every 100 patients in 1975 to 85 nurses for every 100 patients in 1985, according to the American Hospital Association. The economic incentive to reduce the length of hospitalization also adds to the demand for nursing services, because essentially the same amount of care must be given in a shorter period. Since 1983, the average length of a hospital stay has dropped from 7 days to about 6½ days.

The current shortage might be written off as just another fluctuation in the labor supply that will correct itself, except for the precipitous decline in the number of students entering schools of nursing. The number of applicants to all types of nursing programs has been dropping since 1983. These programs include one year of study leading to certification as a licensed practical nurse, two years of study leading to an associate degree in nursing, three years leading to a diploma, and four years leading to a bachelor's degree in nursing. The latter three programs all lead to licensure as a registered nurse.

Enrollment of nursing students seeking licensure peaked at 250,553 in 1983 and dropped to about 218,000 in 1985, according to the National League of Nursing. Between 1983 and 1986, enrollments dropped 12 percent in baccalaureate programs and 19 percent in associate-degree programs. In recent years, the declining interest in nursing has prompted American University, Boston University, Duke University, and Skidmore College to close their undergraduate schools of nursing. Possible closure has been discussed at Georgetown University. Boston University's board of trustees announced its decision to close its school of nursing on June 19, citing as reasons a progressive decline in enrollment since the mid-1970s and the competition of nursing programs at state-supported schools, where tuition costs are far lower.

Besides declines in enrollment, another key indicator of the waning interest among young people in nursing comes in the annual surveys conducted by the American Council on Education–UCLA Cooperative Institutional Research Program. Surveys of first-time, full-time students entering the nation's two-year and four-year colleges provide annual data about the size and characteristics of that age cohort. Kenneth C. Green, associate director of UCLA's Higher Education Research Institute, discussed the annual surveys in relation to nursing at a conference (June 28 to 30) convened by the University of Pennsylvania's School of Nursing. Green said the surveys show that between 1974 and 1986, there was a 50 percent decline in the proportion of first-time, full-time freshmen women who planned to pursue nursing careers. This decline was particularly dramatic during the period 1983 to 1986, when the proportion of freshman women aspiring to be nurses fell by more than one third, from 8.3 percent to 5.1 percent.

The 1986 survey showed that in the freshman class, the number of women intending to be physicians surpassed the number intending to be nurses by a ratio of 10 to 8. By comparison, the 1968 survey showed that the number of freshman women interested in nursing was more than three times the number of women who said they planned to study medicine. Given these stated preferences and the number of students already enrolled in schools of medicine and nursing, Green said that

> by 1990 or 1991 American colleges will award some 14,500 BSN [bachelor of science in nursing] degrees compared to almost 16,000 MD degrees. These last numbers are truly startling and place the much-discussed physician surplus/nursing shortage in a very interesting — and very different — perspective.

A recurring theme that one hears in most discussions about the declining interest in nursing is the argument that the financial rewards for the hospital nurse are not commensurate with the responsibility. Starting salaries are in line with those in other careers on which many young people embark after college graduation, and are above the levels of remuneration for many recipients of associate degrees who do not take nursing positions. But hospital nurses are rewarded very little as they gain more experience, particularly in comparison with physicians and other professionals outside health care. Starting salaries for hospital staff nurses ranged last year from a low of $14,772 at one Dallas-area hospital to a high of $32,885 at a San Francisco hospital, according to the

American Journal of Nursing.[4] Maximum rates for experienced staff nurses reported by the *American Journal of Nursing* ranged from less than $20,000 at some Houston and Dallas hospitals to more than $35,000 in Houston, New York City, Boston, Baltimore, Chicago, San Francisco, and San Diego. The top rate, $48,000, was reported by hospitals in Boston and Chicago.

Several other recent surveys of nurses' salaries provide additional documentation of current levels of remuneration in hospitals. The 1986 survey of hospital and medical school salaries, conducted by the University of Texas Medical Branch at Galveston and studying 33 hospitals, 16 medical schools, and 28 medical centers (representing a 77 percent response rate), reported an average annual starting salary for hospital staff nurses of $20,340 and an average maximum for experienced staff nurses of $27,744. By comparison, a decade earlier the University of Texas survey reported that starting staff nurse salaries averaged $10,404, and an average maximum in 1976 was $13,152. In a survey conducted by the American Hospital Association in the spring of 1987 among 1200 hospitals, in which some 600 responses had been received by August 1, hospitals reported the current average starting salary for staff nurses as $19,676 and the average maximum salary for the same post as $26,362.

Nursing in the United States is characterized by great diversity. Reflections of it abound in the scope of nursing responsibilities in a variety of settings, in different skill levels, organization of services, and educational preparation. The failure of the profession to reach a consensus over issues of educational preparation has contributed to a widespread belief that nursing is unable to get its own house in order despite the obvious need to do so. Curran and an American Hospital Association colleague, Neale Miller, recently wrote: "At a time when the entire system of nursing is in turmoil over titling issues, we run the risk of doing ourselves even greater damage through public exposure of these conflicts."[5]

The essential source of the conflict is a difference of opinion over what is adequate educational preparation for nursing. The ANA has pressed the view since 1964 that only nurses with baccalaureate degrees should be called professional nurses. In 1985 the ANA amplified its earlier position of support for a baccalaureate education, but it also adjusted its policy to the reality that two thirds of all nurses enter practice with associate degrees or diplomas. The ANA called for two minimum educational thresholds: a baccalaureate degree for the professional nurse and an associate degree for a worker to be known as a technical nurse. And the association urged its affiliated state nurses' associations to press for these objectives within their own jurisdictions.

Efforts to incorporate the ANA position into state licensure requirements for entry into nursing practice, either through legislation or regulation, have yielded results in only one state, although the ANA says that many other states (including Illinois, Maine, Minnesota, Texas, and Wisconsin) are pursuing similar action. In January 1986, the North Dakota Board of Nursing amended its administrative regulations to require the program curriculum for registered nurses to confer a baccalaureate degree on a student majoring in nursing, and to require the curriculum for licensed practical nurses to confer an associate degree. The action, challenged in court by several hospitals, has been upheld by the North Dakota Supreme Court.

The American Hospital Association has for many years straddled the question of educational preparation, recognizing that its member hospitals draw their employees from the ranks of all types of programs. The Association includes organizations that represent the interests of schools conferring diplomas (some 190 such programs remain, virtually all of which are operated by hospitals) and baccalaureate programs. In reiterating its support for these different programs in a resolution approved by its House of Delegates in 1986, the Association added that it believes that

> a baccalaureate degree should be an attainable goal for each student and practicing nurse, in or from an associate or diploma program, and provision must be made for crediting their course and experience toward the baccalaureate degree.

One of the American Hospital Association's affiliated membership groups, the American Organization of Nurse Executives, broke with the parent association last October, when its membership voted in favor of imposing a requirement that a baccalaureate education should be the basic preparation for practice in professional nursing. The organization's membership, composed of 4000 hospital nursing executives, also voted to endorse the Gephardt bill mentioned above. The organization's action annoyed the American Hospital Association's president, Carol M. McCarthy, leaving her in the crosscurrent of conflict between hospitals and nurses. The leadership of the American Organization of Nurse Executives has let McCarthy know that it is considering abandoning the organization's affiliation with the American Hospital Association unless she demonstrates a commitment to pursue more aggressively the main goals of the nursing profession that relate to hospitals.

The American Association of Colleges of Nursing and the National League of Nursing — the organization that accredits all schools of nursing — also share the goal of consolidating educational preparation around two kinds of nurses: professional and technical. But the League's membership, reflecting its frustration over nursing's inability to reach a consensus on the issue, directed the League's leadership, through a resolution adopted at its annual meeting in June, to abandon the issue and direct its energies to broader goals, including the development of a national health plan. The League's decision to cast aside the internecine struggle that has long and often unproductively embroiled nursing occurred when, practically speaking, the goals of two preparatory tracks, lodged in educational settings rather than in hospitals, and the

closure of diploma schools have been largely achieved (Table 1).

The issues in educational preparation have been largely ignored by the federal government, but in other respects Washington is becoming more involved with the profession. The shortage of hospital nurses has triggered broader congressional interest in the profession, and legislation is moving to address it. Senator Edward M. Kennedy (D-Mass.) has taken an early congressional lead in addressing the problem, but the real legislative champions of nursing over the years have been Senator Daniel Inouye (D-Hawaii) and Representative Edward R. Madigan (R-Ill.). Even at the DHHS, which has asserted that because there are plenty of nurses all educational support should be terminated, officials are discussing the shortage, at the initiative of its undersecretary, Don M. Newman. The discussions with Newman have concerned the steps that the government can take, short of legislative or regulatory initiatives, to demonstrate its concern about the shortage. The answers have been minimal: DHHS approval of a new national sample survey of registered nurses, an activity the department has periodically conducted (1977, 1980, and 1984) but on which the Reagan administration was dragging its feet before the shortage emerged; implementation of studies costing $1 million (as directed by Congress in the fiscal 1987 supplemental appropriations bill) to address the issues of recruiting and retaining nurses; and the likely convening of a workshop to discuss the problem. The fiscal 1989 budget of the DHHS, which is still under development, currently maintains the administration's long-held position in relation to nursing education: all support should be terminated.

Congress has taken more definitive, though still minimal, action in relation to the shortage. The Senate Labor and Human Resources Committee reported legislation (S. 1402, Nursing Shortage Reduction Act of 1987) on July 7 that would authorize $5 million to study the problem and to fund innovative projects designed to alleviate it. The principal activity that has involved nursing and the DHHS is the support of nursing students and schools. The level of these subsidies reached their peak in 1973, when Congress appropriated $160.6 million for these purposes. But long before the Reagan administration arrived, however, this support began to wane as a consequence of the growing supply of nurses. Since 1981 Reagan has sought to terminate support for nursing as well as all other forms of support for health-professions education that were authorized under the Public Health Service Act. Congress has repeatedly thwarted this effort, and in fiscal 1987 spending for nursing-related activities at the DHHS will total an estimated $72.3 million.

These activities are administered in two agencies — the Health Resources and Services Administration (HRSA) and the National Institutes of Health (NIH). HRSA will spend $53.3 million this year, the bulk of which supports institutions with programs for master's and doctoral degrees ($16.7 million), with programs for nurse practitioners and nurse midwives ($12 million), and with traineeships for professional nurses ($11.7 million). The NIH became a reluctant new partner in nursing pursuits when Congress created, in the Health Research Extension Act of 1985 (P.L. 99-158), the National Center for Nursing Research last year and sited it at the Institutes' Bethesda campus. President Reagan twice vetoed legislation that contained a directive to create the research center, but in both instances Congress overrode his action.

Table 1. Graduations from Registered Nurse Programs, 1970, 1980, and 1986, According to the National League of Nursing.

Type of Program	1970	1980	1986*
	Number of graduates (percent)		
Diploma	22,551 (52.3)	14,495 (19.1)	11,496 (14.4)
Associate degree	11,483 (26.6)	36,034 (47.7)	42,150 (52.7)
Bachelor of Science in Nursing	9,069 (21.1)	24,994 (33.1)	26,365 (32.9)

*Preliminary data

The center, which amounted to an enlargement of a less extensive nursing research enterprise at HRSA, has been granted a sizable budget for a new activity in these times of stringency. In fiscal 1987, the center will spend about $25 million in grants for research and training. Ada Sue Hinshaw, who was a professor and director of research at the University of Arizona's College of Nursing, became the new center's first director on June 7. Madigan, the ranking Republican on the House Energy and Commerce Subcommittee on Health and the Environment, championed the cause of the nursing research center. Although the NIH initially regarded the new research center as detracting from its overriding mission in biomedical research, NIH Director James B. Wyngaarden, in response to a question asked by Representative Carl D. Purcell (R-Mich.), testified on March 17 before the House Appropriations Subcommittee on the Departments of Labor, Health and Human Services, Education and Related Agencies that the NIH's institute directors and leadership now support the activity. "Oh yes, once the decision was made, everybody has gotten behind it," Wyngaarden said. Creation of the research center was perhaps the one legislative initiative in recent years that has been embraced by all of the nursing profession's countless factions.

Before Hinshaw's arrival, Doris H. Merritt served as acting director. Appearing on March 17 before the same House appropriations panel, Merritt defined nursing research as "a scientific study which provides the rationale for effective nursing practice in the home, in the hospital, in the community and in the workplace. It crosses the life span from the fetus to the octogenarian." Merritt said the center would give

priority to investigator-initiated research in new and emerging high-priority areas: support of health-promoting behaviors, emphasis on disease prevention, the care of an aging population, coping with iatrogenic effects secondary to necessary and life-saving therapies, alternative measures of providing nursing interventions for patients

and families of individuals with AIDS [acquired immunodeficiency syndrome] and Alzheimer's disease, and the ethics of decision making in therapeutic choices.

In recent years, as the administration has remained steadfastly opposed to federal support for education in the health professions and as nursing has sought to expand its domain through the creation of independent practices and direct reimbursement, the nursing lobby has devoted more of its energies (but still far less than do hospitals and physicians) to developing more binding ties to Medicare. Nursing has become more sensitive to the program's vast influence on the profession and hospital operations, because of the effects of Medicare's new hospital-payment scheme and because of the proposal by the administration in its fiscal 1988 budget to eliminate (at a projected savings of $310 million) Medicare's support of clinical-education programs in nursing and allied health professions.

The relatively new efforts of nursing to seek direct payment from Medicare have placed the profession at direct odds with organized medicine, which, given all the other pressures for change in the traditional methods of delivering heath care, is in no mood to yield ground to the interests of any other provider. Nevertheless, nursing has made some headway in establishing more direct relations between Medicare and the profession.

The most successful link that has been established between Medicare and nursing in relation to direct billing came as a consequence of legislation enacted as part of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). After a transition period (October 1, 1987, to December 31, 1988), all anesthesia services furnished by certified registered-nurse anesthetists will be paid under Part B on the basis of a fee schedule established by the DHHS. When a claim is filed, payment will be made to the nurse anesthetist or to a hospital, physician, or group practice with whom such nurses are employed or to whom they provide services under contract. A nurse anesthetist (and his or her employer) must accept Medicare's fee as payment in full for the services rendered.

Nursing is also pursuing another path to direct payment, through legislation introduced by Representative Gephardt. The measure would authorize the Health Care Financing Administration to contract with community nursing and ambulatory care centers in much the same fashion that Medicare now contracts with health maintenance organizations. The nurse-sponsored organizations would provide all Medicare Part B services except physician, x-ray, and laboratory services. The bill has attracted 70 House sponsors, and efforts are being made to incorporate the measure in the next omnibus budget-reconciliation bill. The AMA's House of Delegates approved a report at the Association's recent annual meeting, filed by its board of trustees, which expressed strong opposition to the legislation.

The issues facing nursing are many, and there are no easy answers for any of them. The data and the demographics indicate that there will be no rapid reversal in the current imbalance between the growing demand for hospital nurses and the available supply. Among the realities that must be acknowledged is the change in values in American society that influence how young people choose careers. The dominant goal of college freshmen 20 years ago was "developing a meaningful philosophy of life." That goal has now been replaced by "being very well off financially," surveys show.[6]

It is clear from the literature and, most recently, from some interesting focus-group discussions conducted under the aegis of the American Hospital Association that, as the Association said in a new publication, "nurses want and need both recognition and respect for their hard-won knowledge and skills. . . . Nurses need to know that others in the health care system value their contributions."[7]

Central to any strategy that seeks to improve the lot of nurses and thus to begin to address the problem of shortage is the need to recognize the interdependence of nurses, hospital administrators, physicians, third-party payers, and patients. Unless all parties are involved in the dialogue as nursing charts its future, the conflicts that dominate nurses' relations with physicians — at least at a collective level — will prevail. Although this point was not the focus of the discussions at the University of Pennsylvania's recent conference, it certainly was the sense of those in attendance.

One of those attending, Dr. Samuel O. Thier, president of the Institute of Medicine, the organization that conducted the last comprehensive review of issues in nursing education,[8] said that without broad participation, progress will be difficult. He elaborated on his views in this regard in an interview.

The issues surrounding nursing are so central to health care that the medical profession can't afford to watch from the sidelines. Physicians must balance their competitive concerns toward nursing with a keener recognition that hospitals cannot operate without nurses. And we must all be sensitive to the fact that what's more important than professional prerogatives is designing a system that best meets the needs of patients.

References

1. McCloskey JC, Grace HK, eds. Current issues in nursing. 2nd ed. Boston: Blackwell, 1985.
2. Mullner R. 45% more community hospitals closed in '86. Hospitals 1988; 61(9): 32, 34.
3. Prospective Payment Assessment Commission. Report and recommendations to the secretary, Department of Health and Human Services, April 1, 1987. Washington, D.C.: Prospective Payment Assessment Commission, 1987.
4. DRGs still stymie economic gains for nurses; paychecks rose only 4% in '86. Am J Nurs 1987; 87:114-23.
5. Curran CR, Miller N. Looking beyond the entry issue: implications for education and service. New York: National League for Nursing, 1986.
6. Astin AW, Green KD. The American freshman: twenty year trends 1966–1985. Los Angeles: American Council on Education/UCLA, 1986.
7. American Hospital Association. The nursing shortage: facts, figures and feelings, research report. Chicago: American Hospital Association, 1987.
8. Institute of Medicine, National Research Council. Nursing and nursing education: public policies and private actions. Washington, D.C.: National Academy Press, 1983.

PREPARED STATEMENT OF SENATOR JOHN HEINZ

Mr. Chairman,

I commend you for convening this hearing on such an urgent and difficult problem. This nation's shortage of nurses, particularly in the critical care areas, is a growing concern and by all estimates will continue to grow in the coming years.

The prospect that we might soon not have enough qualified nurses to meet our needs for medical care in hospitals, nursing homes and in-home settings is certainly unsettling. Hospitals unable to find enough nurses will be forced to reduce hospital beds, delay some medical procedures, or place increasing demands on their existing nursing staff. Hospitals have already found themselves closing critical care beds because there were not enough nurses to adequately staff them. In some cases, patients have been turned away from hospitals because there are not the nurses to take care of them. It is ironic that our efforts over the years to improve access to hospital care through health insurance coverage should be thwarted by a looming shortage of trained professionals to provide that care.

This impending emergency is the result of a number of factors. An increasing prominence of elderly and more frail persons, a greater prevalence of certain protracted illnesses such as Alzheimer's and AIDS, and a improved ability to sustain life is accelerating the demand for skilled, bedside nurses. Medicare's Prospective Payment System has only made the demand greater. While hospitals may find themselves with fewer patients under PPS, these patients are sicker and require more intensive nursing care. In order to minimize hospital stays, hospitals are using more nurses around the clock to expediently provide the necessary care before the patient is discharged. All of these factors contribute to the increased need for clinical nurses.

There are also a myriad of factors within the field of nursing which serve to further compound the shortage. The shortage of nurses has not, as would ordinarily be expected, resulted in a corresponding increase in nurses pay. A recent UCLA study indicates that, compared to ten years ago, fewer young women entering higher education are considering a career in nursing. Weekend and shift work make balancing a career in nursing and a home and family even more difficult than the typical 9 to 5, five day a week career. Furthermore, the increased demands being placed on nurses without comparable recognition of it in terms of pay and in many instances,

professional respect, make for dissatisfaction and a high turnover rate.

Short staffing means that nurses are each responsible for more seriously ill patients than in the past. They do not have the time to offer their patients the special attention that the sick need and, by vocation, nurses want to offer. When a nurse doesn't have the time to hold a hand to reassure someone facing surgery, wipe a fevered brow or adjust the pillows so that the patient can see the leaves changing on the tree outside the window, the patients suffer, not in quantifiable terms, but they lose the sensitive attention the ill need. In the same sense, nursing is a field that attracts the very compassionate. When they are unable to have the interaction with their patients that has come to be known as "nursing," their satisfaction in their work diminishes.

Today we are confronting a complicated crisis in a field in which there is no leeway or substitute. It has been said that a patient is hospitalized, not as much for physician care, but rather to receive necessary nursing care. A shortage of nurses translates into hospitals being forced to close beds and patients receiving less personal attention from tired, overworked nurses. Any solution to this issue will require a combined effort of government, hospital administrators and nurses themselves. These efforts should focus not so much on the symptoms and short-term stop-gap measures, but address both the immediate and long range problem of how to attract and retain enough clinical nurses to meet our increasing needs.

83-151 O - 88 - 3

Prepared Statement of Charles Jenkins

The American Hospital Association, which represents nearly 5,400 institutions and over 45,000 personal members, including the 4,000 members of the American Organization of Nurse Executives, is pleased to have this opportunity to present its views on the current nursing shortage. Hospitals are deeply concerned about this manpower crisis because of the increasing demand for highly skilled nursing personnel.

I am Charles Jenkins, a former member of the AHA Board of Trustees, and chief executive officer at Helix Health System, which is composed of Union Memorial Hospital, a 353-bed institution, and Franklin Square Hospital, a 421-bed institution. With me today is Dr. Margaret McClure, Executive Director for Nursing at New York University Medical Center and AONE past president. Dr. McClure and I would like to discuss AHA's concerns about the nature and extent of the nursing shortage and the role that the federal government can play in assisting the health care industry to avert a crisis.

DIMENSIONS OF THE NURSING SHORTAGE

Shortages of nurses have recurred over the years. The current shortage, however, is more serious than previous shortages in that, for the first time, the shortage cuts across all regions of the country, all types of hospitals, and all types of nurses.

The average percentage of vacant positions for registered nurses in hospitals doubled between September 1985 and December 1986, almost reaching the levels of the last national nursing shortage of 1979. Over half of the hospitals responding to an AHA survey earlier this year reported that a shortage of staff registered nurses was a problem for their institutions. Some variation does exist--more hospitals with over 300 beds and hospitals in urban areas characterized their problem as severe--but almost one fifth of all hospitals reported that the shortage was severe. Hospitals facing a shortage are increasingly filling budgeted vacant positions with temporary staff. The mean

number of RN shifts filled by temporary and/or contract personnel rose from 6.7 in September 1985 to 10.8 in April 1987. This strategy is a costly and, at best, a short-term solution to address the shortage.

The situation is exacerbated by a growing demand for more skilled personnel as a result of the increase in the severity of illnesses and intensity of services needed by today's hospital patients. Increasing severity of illness and the consequent rise in the level of nursing care required is reflected in the changing ratio of nurses to patients, which rose from 50 nurses per 100 patients in 1975, to 85 nurses per 100 patients in 1985--a 70 percent increase. Shortened length of stay and greater use of outpatient services, rising patient acuity, and increasingly sophisticated medical technology point to a continued demand for more highly skilled registered nurses for the short and long term.

Demographic trends are projected to heighten the need for skilled nursing services in hospitals as well as long-term and home care agencies. The elderly, who are hospitalized more frequently than average and stay longer once admitted, are projected to make up 21 percent of the population by the year 2040 as opposed to the current 12 percent. In addition, the over-85 population--the fastest growing subsegment of the older population--uses twice as many hospital days per capita as persons aged 65 to 74 years. These patients require more intensive and complex care, generally labor-intensive nursing services. Hospitals are thus bearing the burden of providing intensive nursing care to patients with rising acuity levels and a wider range of services to the growing elderly population, creating the need for intensive nurse recruitment programs.

CAUSES OF THE SHORTAGE

There are three general factors contributing to the nursing shortage: a diminishing applicant pool to nursing schools, staff turnover in hospitals, and rising demand for registered nurses both within and outside hospitals.

The supply of new nurse graduates is expected to decrease well into the next decade because it is becoming harder to attract talented people into the field. Admissions to all types of nursing schools, as reported by the National League for Nursing, dropped by nearly 20 percent from July 1985 to July 1986. Other careers that promise more prestige and higher wages such as medicine, law, or engineering are more accessible and attractive to talented women who would traditionally have pursued nursing and teaching careers.

Staff retention is also a problem. The National Association of Healthcare Recruitment Nurses reports turnover within hospitals at approximately 20 percent--a possible reflection of dissatisfaction with increased workloads, low wages, and limited upward mobility. If estimates of recruitment, orientation, and replacement costs are totaled, the average cost of turnover is $20,000 per nurse hired. With a 20 percent turnover rate, hospitals are spending $3.2 million annually simply to replace vacant positions with no guarantees of better educated or more experienced nurses. Hospitals are trying to develop innovative incentive programs and improvements in the work environment to reduce this expense.

Finally, the composition of nursing personnel employed in hospitals has changed since 1984. Hospitals increasingly employ a larger proportion of registered nurses relative to licensed practical nurses and nurse aide/orderly staff. Almost one-half of hospitals reported an increase between 1986 and 1987 in the number of registered nurses employed; a corresponding 36 percent of hospitals reported a decrease in licensed practical nurses and a 38 percent decline in nurse aide/orderly staff. Rising patient acuity and greater cost savings with a smaller but more highly skilled registered nurse staff are two possible explanations for this change. Furthermore, as more and more skilled care is furnished outside the hospital, in nursing homes and at home with the assistance of skilled nursing personnel, the need for highly trained nursing staff will continue to grow.

RESPONSES TO THE NURSING SHORTAGE

The ever increasing demands for skilled nursing personnel make continued funding of education programs more necessary than ever. AHA believes that the federal government should expand its support of nursing education. It is critical not only that the federal government not cut back on current support under Medicare for the direct costs of nursing education, but that it also expand its support. In expanding support for the costs of clinical nursing education, AHA recommends that Medicare recognize the diversity in nursing education by supporting both hospital- and collegiate-based programs.

Current funding for entry-level nursing education is inadequate. In order to attract and maintain qualified individuals in undergraduate nursing programs, it is essential that federal funding and financial aid be increased. Also, targeted funds to support educational mobility opportunities for the 450,000 licensed practical nurses in this country are needed as hospitals shift the skill mix of their nursing staffs in favor of registered nurses. Educational mobilility programs are uniquely designed to enable licensed practical nurses to acquire the nursing education needed for registered nurse licensure.

Funding for entry level nursing education is essential, but should not eclipse funding for advanced nursing education. AHA surveys indicate that over 50 percent of hospitals report middle management vacancies--jobs that require advanced nursing education. Other specialists such as nurse practitioners or nurse anesthetists are also important to meet the practice demands of a rapidly changing delivery system.

AHA recognizes the need for innovative programs to address both retention and nursing care delivery. As noted earlier, improved retention could provide significant financial and human resource benefits. AHA supports a study of hospitals which have improved retention and the testing of new strategies. The rapid changes in technology and hospital patient acuity point to a need to support studies of nursing care delivery models that will meet patients' needs into the next century.

Of course, making funds available to educate additional nurses will not solve the problem unless hospitals are able to pay nurses the competitive salaries needed to attract people into the profession. Adequate compensation will not be possible if hospitals are not adequately paid for the care being delivered. Thus, one critical way the federal government can and must help in addressing the nursing shortage relates to its role in financing health care services.

The federal government can play several roles in this regard. One is to help stimulate private sector health insurance coverage for workers and their dependents. Another is in financing care for the medically indigent, those unable to obtain adequate private health coverage. This is accomplished primarily through the Medicaid program. The federal government must insist on adequate provider payment for Medicaid services given the increased flexibility granted under OBRA 1981 in setting payment levels.

Finally, the federal government must provide adequate payment to hospitals under the Medicare program. The most recent data indicate that many of the assumptions--concerning both changes in the intensity or case mix and inflationary pressures--made over the past four years in setting prices have been incorrect. Per-case costs have risen substantially since the first year of prospective pricing, in contrast to the assumptions made by ProPAC, Congress, and the Administration in setting update factors. This supports the observation that intensity is rising within DRGs; yet, price increases since the inception of PPS have not kept pace with this change in hospital case mix. In addition, data on hospital wages available from both AHA surveys and the Bureau of Labor Statistics indicate that the market basket used by HCFA to set prices does not accurately reflect inflationary pressures facing hospitals for nursing and other personnel. Hospital wages appear to have risen faster than wages in other sectors of the economy, which would be consistent with the reported shortage of nursing and other professional personnel, although the HCFA market basket relies extensively on non-hospital wage data. To correct this problem, HCFA should be directed to base the labor component of the market basket on hospital wages rather than on a combination of hospital and non-hospital wages.

LEGISLATION AFFECTING THE NURSING SHORTAGE

The Finance Committee has two bills before it this year to address the nursing shortage: S.1765, the Nursing Manpower Shortage Act of 1987, introduced by Sen. Mitchell, and the Medicare Nursing Practice and Patient Care Improvement Act of 1987, to be introduced today by Senator Durenberger. Both of these bills contain important ways for Congress to address the nursing shortage.

S.1765 has five parts:

1. A new program--modeled after Medicare financing for physician education--for financing the clinical education of nurses pursuing masters and doctoral degrees;

2. Community Nursing Organization demonstrations, enabling nurses to provide ambulatory and home care services to the elderly on a prepaid, capitated basis;

3. Medicare and Medicaid reimbursement to nurse practitioners for certification and recertification visits for nursing home care;

4. Medicare reimbursement for certified nurse midwives and pediatric nurse practitioners; and

5. A study of the impact of current Medicare and Medicaid regulations on the nursing shortage.

Senator Durenberger's bill would authorize grants and contracts to hospitals and nursing homes for demonstrating and evaluating the cost-effectiveness of innovative nursing practice models and methods for improving the nurse's role and working conditions.

AHA applauds these senators for formulating potential solutions to the nursing shortage. We believe that both bills contain provisions that help to address the shortage and look forward to working with the sponsors and the rest of the committee in refining these proposals as they move forward.

CONCLUSION

AHA recognizes that a shortage of registered nurses is not only a problem for its membership but also a challenge that may adversely affect the quality of health care delivered to the American public. With this in mind, the AHA has formed an ad hoc committee to study the current nursing shortage and make recommendations to the AHA Board of Trustees within six months. Other initiatives undertaken at AHA include ongoing national data collection to quantify the scope and impact of the shortage; technical assistance materials on recruitment and retention strategies to assist hospitals to respond effectively; and a national public relations campaign to improve the image of nursing and enhance its attractiveness as a career choice.

I want to offer to this subcommittee the expertise and information developed by the AHA as you proceed in your deliberations. We are committed to seeking new strategies to address this human resource problem and maintain the level of high quality care provided to patients within our member institutions.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Good morning. We are here today to examine the current shortage in the supply of nurses in our nation's hospitals, nursing homes and home care agencies. We will examine the causes of this shortage and look to possible solutions to this critical problem which affects the health care of all Americans, but in particular the elderly, who most rely upon a disproportionate share of nursing care to survive.

Since the days of Florence Nightingale, when women had few career options outside of marriage, nursing has been considered an honorable profession for women. But women's lives and options have changed dramatically since the 19th century. According to a recent survey by the Higher Education Research Institute at the University of California at Los Angeles, for the first time in our history there are more freshmen women in four-year institutions aiming for careers as doctors than as nurses.

While this is indeed a testiment to increased opportunities and equality for women in our society, it has a detrimental effect upon the need to continue to provide an adequate supply of nurses in the nation's hospitals, nursing homes, and other health care facilities.

As our population ages, the need for nursing care increases - particularly, the need for nurses with specialized training and competency in geriatrics and rehabilitation.

Unfortunately, the supply of nurses and enrollment in schools of nursing are declining. According to the latest federal projections, by 1990, demand for

baccalaureate-prepared RNs will exceed the supply by 390,000; by the year 2000, the gap is expected to grow to more than a million.

In recent months we have read about a shortage of nurses here in the District of Columbia which created a serious problem for one of the local hospitals. This problem is widespread and affects institutions in both urban and rural areas. The Maine Medical Center - the largest and most comprehensive hospital in my state with an occupancy rate of over 95% - has been forced to eliminate the use of 10 beds because they cannot find the nurses to staff them.

The reasons for the current situation are complex, and the solutions will not be simple. We must examine the causes of this problem and work together to develop workable solutions.

Earlier this year I joined with Senator Kennedy and others in sponsoring legislation which is intended to establish programs to reduce the shortage of professional nurses. This bill, the Nursing Shortage Reduction Act of 1987, passed the Senate on August 5 and is awaiting action in the House. I am hopeful that this legislation will be enacted into law before the end of the year.

On October 7, I introduced the Nursing Manpower Shortage Act, which would provide payment for direct graduate medical costs related to nurse clinical training through the Medicare program.

Each of these bills attempts to address the nursing shortage in a different way. Senator Kennedy's bill is intended to address the RN staff nurse shortage, while mine is intended to provide a career track for the graduate level nurse.

One of the reasons often cited for nurses leaving the profession is a lack of career advancement beyond the first few years. While the entry level RN makes a reasonable salary, within 5 to 7 years she has peaked out in terms of income and responsibility. My bill would create incentives for nurses to go on beyond the baccalaureate level to pursue careers as nurse practitioners, nurse midwives, and Master's and Doctoral level nurses.

I look forward to working with interested organizations in reviewing and improving the provisions of the Nursing Manpower Shortage Act. I hope that this hearing today will be the beginning of constructive dialogue between the health care community and Congress in finding workable solutions to the nursing shortage problem which may threaten the health care of all Americans.

PREPARED STATEMENT SENATOR JOHN D. ROCKEFELLER IV

Thank you, Mr. Chairman. I know how concerned you are about the nursing shortage emerging throughout the country. The legislation you have introduced, the "Nursing Manpower Shortage Act," proposes some compelling ways for the federal government to play a greater role in alleviating this problem. I commend you for the contribution you're making by increasing awareness of this problem in Congress and by trying to develop solutions.

As a rural and poor state, West Virginia often finds itself suffering shortages in professions such as medicine and teaching that are not felt as acutely or broadly in other states. In the case of nursing, however, it appears that we are by far not alone. Nationwide, nursing schools are seeing their enrollments drop, hospitals are reporting vacancies, and the demand for nurses by other aspects of the health care industry is growing.

These same signs of the nursing shortage appear in my state. Some of our nursing education programs are struggling to fill their classes. And as they turn out less nurses, the demand increases. One of our major hospitals, in Charleston, would hire as many as 100 new nurses if they could find them.

I'm especially disturbed by what nurses tell me. They are clearly worried about the shrinking of their ranks. They say the demands on them in hospitals are growing, while their salaries are not and working conditions don't improve. They honestly believe that the quality of care is endangered. When a nurse has to work 24 or more hours in a row, caring for patients with more acute problems, it seems we should be worried, too.

Mr. Chairman, I believe Congress must try to help prevent a severe and long-term nursing shortage from occurring. As you know, the Senate approved Senator Kennedy's "Nursing Shortage Reduction Act" in August. Once the House acts on it, that bill will make it possible to experiment with various approaches to improving the recruitment and retention rates for nurses.

I think the federal government has a special responsibility to help attract lower-income and minority citizens into nursing. There were serious cuts in nursing and medical education assistance in the early Reagan years, and those cuts have directly shut out students whose families can't afford the cost of nursing education. More financial aid must be extended and let's link it whenever possible to service in shortage areas.

I also recognize the importance of Medicare, Medicaid, and other federal health programs in contributing their fair share to the costs of nursing education and nursing services for the elderly, the poor, and others served by those programs.

But as or more importantly, the health care industry, nursing schools, and others also must play a major role in turning this situation around. Recruitment efforts are going to have to reach out to men. Those who hire nurses must improve working conditions. Women simply will take advantage of the fact their employment choices are rapidly increasing, and men are going to continue avoiding nursing unless their perception of the profession changes and the reality of salaries improves.

This hearing will help to educate us about an issue where there is much to learn and think about. As ideas unfold for addressing this problem, I know this committee will want to contribute to solutions. But the witnesses also represent organizations in a position to spur actions in individual states, in education, and in the health care industry that will attract more men and women to the nursing profession and convince them to stay. It's obvious that such action should be taken sooner rather than later -- in time to ensure that enough qualified nurses are available to provide the care needed by patients.

Prepared Statement of Neville Strumpf

Mr. Chairman, I am Neville Strumpf, Ph.D., R.N., Assistant Professor and Director of the Geriatric Nurse Practitioner Program in the School of Nursing at the University of Pennsylvania. Today I am testifying on behalf of the National League for Nursing (NLN) which is the official accrediting agency for nursing education, and represents approximately 2,000 agencies and 15,000 individuals dedicated to improving the quality of health care through nursing education.

The NLN very much appreciates the opportunity to present our views and recommendations on the critical problem of the nursing shortage facing the nation. We also want to commend this Subcommittee for holding these hearings and for its willingness to consider a federal response to this health care crisis.

At the outset, we would like to emphasize that the current shortage of registered nurses is a multi-faceted problem. At the same time, however, it is a problem that has been extensively examined and for which there are a number of thoughtful and well documented recommendations. Part of the problem facing us today is a failure to implement these recommendations. The NLN believes that we must take steps to implement both short-term and long-range plans to assure an adequate supply of nurses across the health delivery system. Failure to do so threatens the quality and accessibility of health services for all and especially for our most vulnerable elderly and low income citizens.

The impact of the nursing shortage is particularly threatening to the more than 30 million Americans over age 65 who are entitled to benefits under the Medicare program. This segment of the population uses health services more extensively and is therefore at high risk for the consequences of inadequate or non-existent nurse staffing. The elderly are typically victims of chronic diseases and can benefit most from nursing care, both in the acute phases of illness and especially in post-acute care settings.

Further, the NLN believes that shortages of appropriately qualified nursing personnel substantially affect the quality of care and the prospects for recovery and rehabilitation. The chronically ill -- a growing portion of the Medicare population -- need nursing care that is continuous and affordable and assists them to maximize their ability to lead healthy, fully functional and productive lives. Current deficits in the availability of nursing services compromise our capacity to assure quality and waste our limited resources.

Documentation of the Nursing Shortage

It is apparent from our review of the evidence describing the scope and magnitude of the nursing shortage that solutions will have to be designed to address a series of different problems. NLN data reveal that 1986 admissions and enrollments for nursing education programs continue the dramatic downward spiral that began in 1983. Preliminary analysis of our data show that overall enrollment declined by more than 11 percent in 1986, following annual declines of 13.4 percent in the two prior years. Admissions to baccalureate programs alone experienced a 17 percent drop in 1986. Part of this trend may be due to changing demographics, but we believe that more and more young people are also facing many attractive career opportunities from which to choose. Thus, nursing must compete with other professions as never before in today's market.

For these reasons and more, we believe that the current shortage is likely to grow worse in the years ahead. A recent report to Congress from the Department of Health and Human Services on health manpower needs for the health delivery system projects requirements for 390,000 nurses with baccalureate degrees by the end of the decade. Compounding the problem in the future is the general decline in the pool of college age persons as a result of falling birth rates.

Turning now to more current evidence of the shortage of nurses, we call your attention to the recent survey by the

American Organization of Nurse Executives (AONE) citing the RN vacancy rate for hospitals in 1986 at almost 14 percent -- nearly double the vacancy rate for 1985. The number of hospitals reporting no vacancies at all was cut in half, from 35 percent in 1985 to 17 percent in 1986. More specifically, the highest vacancy rates in hospitals were in the critical care units and medical and surgical services. Two-thirds of hospitals needed more than 60 days to recruit RNs for medical/surgical services and over 90 days to fill intensive care nursing positions.

These data suggest that the nursing shortage is pervasive and worsening. It is also important to note that the AONE survey shows virtually no shortage of nursing personnel in home and community based care systems. The attractiveness of nursing opportunities within the health care marketplace, but outside of the hospital setting is also an important reason for the concentration of the shortage in acute care hospitals.

A common misconception concerning the nursing shortage is the belief that there is a sufficient pool of registered nurses, and the challenge is to induce those who have left active practice to return to the workforce. Practice data from the American Nurses' Association (ANA) indicate that the participation rates of nurses in the workforce is already quite high. Of the 1.4 million registered nurses in the United States, almost 80 percent of them are employed in nursing positions.

No overview of the nursing shortage crisis would be complete without some comments on nursing compensation and working conditions. The average hospital nurse earns $20,340. Nurses with ten years of experience earn on average a salary of $27,744. While entry level salaries for registered nurses may be competitive with other professions prepared at the baccalaureate level, compression of the wage structure creates profound retention problems in the nursing profession.

Studies of the Nursing Shortage

During the past decade there have been several studies of the nursing profession with particular emphasis on strategies for assuring an adequate supply of nurses. In 1981 the American Hospital Association formed the National Commission on Nursing, a multidisciplinary group charged with developing recommendations to improve recruitment and retention of nurses, to enhance job satisfaction, to maintain and increase the competence and productivity of nurses in practice, and to assure the quality of nursing care.

After several years of deliberations the Commission in 1984 published its report. At the center of its findings was recognition of three factors that shape the practice environment: 1) nursing leadership roles; 2) working conditions; and 3) nursing education. In each of these areas the Commission formulated recommendations. Three of the Commission's 18 recommendations bear repeating:

1. Nursing should be involved in policy development and decision making throughout the health care organization.
2. Effective nursing practice is found where conditions of nurse employment foster professional growth and development. Approaches such as flexible scheduling, appropriate staffing patterns, career advancement programs and recognition for achievement should be explored and developed.
3. Current trends in nursing toward pursuit of the baccalaureate degree as an achievable goal for nursing practice and toward advanced degrees for clinical specialization, administration, teaching and research should be facilitated.

In 1983 the Institute of Medicine completed a two year study of nursing and nursing education mandated by Congress. That report included over twenty recommendations many of which are similar to the findings of the Commission. Two areas emphasized by the IOM report that are pertinent today are: first, the call

for federal support of expanded programs in geriatric nursing; and second, improving the use of nursing resources by encouraging health care institutions to improve the practice environment.

Finally, we would like to note that more recent studies by the American Academy of Nursing and an AHA market research project corroborate the principal findings of the two studies noted above. By way of summary, the AHA study identified the following factors as contributing to the current shortage from the perspective of practicing nurses:

- Financial rewards are not commensurate with responsibility.
- Opportunities for upward mobility are lacking.
- Nurses have insufficient authority and autonomy.
- Work demands are increasing because of rising severity of illness.
- Nurses do not participate in management decisions regarding practice standards and support services.

Remarkably little progress has been made in implementing the recommendations identified by these distinquished panels. The NLN strongly believes that a series of steps need to be undertaken to move the nursing profession toward the attainment of its professional goals. Many of these steps should be taken by the profession itself and by the leadership of the health care system. Other steps require governmental assistance. In the balance of our statement we want to set forth our positions on federal legislation that can assist and reinforce private sector initiatives.

Federal Policy Recommendations

Mr. Chairman, the NLN would like to express its sincere appreciation for the contribution you have made through your introduction of S. 1765. This bill includes a number of critically important Medicare policies that would serve as a catalyst for similar reforms in other health financing programs.

The NLN supports this legislation and is pleased that some of its provisions have been included in the Committee's budget reconciliation legislation. We hope the remaining sections of the bill will also be reported favorably by this Committee.

We would like to take special note of your support in S.1765 for extending Medicare support to advanced clinical education in nursing in a manner similar to the support currently available for physician post-graduate education programs. The preparation of nurses at the masters and doctoral level as clinical nurse specialists meets a critical need and offers professional advancement opportunities vital to the future attractiveness of the nursing profession. We also strongly agree with the priority you have given to funding of those programs for geriatric nurse practitioners or gerontological nurse specialists in light of the contribution of these specialists to the needs of Medicare beneficiaries.

For some time the NLN has urged Congress to recognize the role of nurse practitioners in providing services to patients in skilled and intermediate care nursing facilities. By authorizing direct payment for such services and allowing nurse practitioners to certify and recertify the need for nursing home services, S. 1765 would promote access to vitally needed services in a rapidly growing segment of the health system. Similarly, direct payment for the services of pediatric nurse practitioners and nurse midwives assures Medicare beneficiaries equal access to providers who are increasingly recognized under private sector health programs.

Before leaving the discussion of S. 1765, we very much want to endorse the provision requiring the Secretary of HHS to develop demonstrations of the feasibility of Medicare risk contracts with community nursing organizations (CNOs). With the explosion of ambulatory services and the documented cost-effectiveness of preventive care and case management, we believe that community nursing organizations can assure quality and

economy for Medicare beneficiaries. Recently, McGraw-Hill's Medicine and Health reported that 20,000 nurses have started independent health delivery organizations ranging from primary care clinics, and birthing centers to home health agencies. Medicare beneficiaries should be able to obtain coverage for care provided by CNOs and similar entities.

Mr. Chairman, the NLN would like to express its support for the legislative provisions contained in S. 1402, the Nursing Shortage Reduction Act, sponsored by Sen. Edward Kennedy (D-MA). This measure, which passed the Senate on August 5th, also is quite consistent with the recommendations of the several studies of the nursing shortage discussed earlier. It illustrates how federal resources can aid the profession in finding new ways to more effectively recruit and retain nurses in clinical practice.

By establishing grant programs to support innovative practice models in both hospitals and long-term care institutions, S. 1402 recognizes the importance of finding new ways to restructure the clinical practice environment. If we do not make progress toward greater professional rewards and more practice autonomy, nursing will be rejected as a career choice by those who find the opportunities in business, government and other professions more attractive.

At the same time, our efforts to assure an adequate supply of nurses for the future must not overlook the importance of more effectively presenting nursing to young people as they are contemplating educational and career choices. S. 1402 makes grants available to support model nurse recruitment centers. We support this provision and urge that it be expanded. Unless we are able to turn around the dramatic decline in the number of students electing a nursing education, our other efforts to address the nurse shortage will fall far short of the needs we have identified.

Mr. Chairman, we have sought to present a comprehensive agenda to deal with the nursing shortage crisis. The proposals that you have endorsed and others pending in the Congress represent critical first steps. For our part, we are committed to strengthening the quality of nursing education and to advocacy on behalf of public policies that promote full access to nursing services for all Americans.

Thank you again for this opportunity to present our comments and recommendations. We look forward to working with you and the Subcommittee in the promotion of our shared goals. I will be pleased to respond to any questions you or other members of the Subcommittee may have.

Prepared Statement of Jan Towers

I am here today to express the concerns of the American Academy of Nurse Practitioners regarding the current Nursing shortage in our country. At a time when a diversity of service-oriented occupations are available to young people graduating from our secondary schools, the need to make the profession of Nursing an attractive and desirable occupational choice is extremely important.

This situation becomes particularly acute when one considers also the increased need for nurses to provide services for patients in the increasingly diversified health care systems in our country. A particular problem arises in areas of health care requiring the utilization of nurses in advanced practice, for with the shortage of nurses in our communities comes a reduction in the potential pool for nurses entering programs to prepare them for advanced practice. The arrival of this shortage, when the demand for specialists such as Nurse Practitioners is increasing significantly across the nation, makes the situation particularly acute. The need for attention to the alleviation of the nursing shortage through the support of innovative nursing education and nursing service activities is now, when consumers expect more and better care for their health care dollars.

Unfortunately this shortage will have its major impact in the provision of care to the underserved populations in our country. Yet it is in the economy's best interest for Congress to attune itself to methods for providing quality cost effective care for these people. One of these methods is to assure the preparation and remuneration of cost effective providers of health care for these populations, nurses.

For this reason, we would call your attention to the need for funding, first to assure quality basic education for nurses, but also to prepare nurses at the graduate level to undertake nursing roles for which there is an increasing demand in all segments of the population and particularly among women, children and the elderly. In a report from the Congressional Budget office as early as 1979, a summarization of findings of numerous studies focusing on Nurse Practitioners demonstrated that Nurse Practitioners have

performed safely and with high levels of patient satisfaction.[1] Nearly ten years later, the December 1986 report of the Office of Technology Assessmenta presents a similar report. In that report, patients not only rated themselves highly satisfied with the care they received from Nurse Practitioners but also gave particularly high scores in the areas of "personal interest exhibited to the patient, reduction of the professional mystique of health-care delivery, amount of information conveyed and cost of care."[2]

Some of the innovations initiated in the 100th Congress to provide funds for graduate nursing education, such as Senate Bill 1441 and Senate Bill 1402, are needed at this time in order to recruit individuals to enter specialist roles in nursing. Without such funding, many qualified candidates may be unable to embark on careers in nursing or programs in advanced practice. Incentives and assistance are needed.

Not only is legislation for funding educational and nursing service programs needed, but additional legislation which will allow nurses such as Nurse Practitioners to function more efficiently and effectively must be passed. Bills such as SB 101 providing for medicare reimbursement for Nurse Practitioners contracting with long term care facilities to certify for medicare eligibility, and Senate Bill 1661 which provides for the establishment of nurse managed community health care centers are badly needed. The absence of legislation enabling Nurse Practitioners to receive payment for practice particularly among underserved populations serve as a potential deterrent to the Nurse Practitioners willingness to stay in these settings. Such enabling legislation motivates and enables a nurse to enter a field of health care, which aside from these restraints is rewarding and productive, especially from the consumers point of view. The biggest reward a Nurse Practitioner obtains

[1] Congressional Budget Office, U.S. Congress. Physician Extenders: Their Current and Future Role in Medical Care Delivery. Washington, D.C., U.S. Government Printing Office. April, 1979.

[2] Office of Technology Assessment, U.S. Congress. Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy Analysis. Washington, D.C., U.S. Government Printing Office. December, 1986.

comes when a serious illness is prevented in a child, when a women or man understand the mechanisms for preventing Aids, or an elderly patient's hypertension and diabetes is managed in such a way that that individual is a comfortable and productive member of the community.

The need for legislation to enable Nurse Practitioners to serve this population, particularly in the areas of medicare and medicaid is sorely needed and long overdue. Not having to overcome these funding or reimbursement obstacles would go a long way toward reducing consumer and Nurse Practitioner frustration. It would instead facilitate the provision of documented quality health care through more efficient use of the skills of all Nurse Practitioners regardless of their specialty, Family, Adult, Pediatric, Obstetric/Gynecologic Geriatric.

In conclusion, we would ask that the Senate seriously consider the need for additional funding for recruitment and preparation of nurses for basic and advanced practice roles particularly among underserved populations. In addition, we would ask for serious consideration of the need for legislation which enables all Nurse Practitioners to be reimbursed for the services they are providing, particularly medicare and medicaid.

PREPARED STATEMENT OF PAUL WILLGING

Good morning. I am Dr. Paul Willging, executive vice president of the American Health Care Association (AHCA), the largest organization representing America's long term care providers. AHCA's membership exceeds 9,000 nursing homes which provide care for over 950,000 chronically ill patients each day.

I want to commend the Chairman and the members of this subcommittee for addressing this morning one of the most critical issues affecting health care providers in this nation -- the shortage of nurses.

The growing nurse shortage is creating serious staffing problems and resulting in unfilled registered nurse (RN) vacancies in hospitals and long term care facilitites in all geographic areas. For long term care providers, the nursing shortage is particularly critical. The availability of qualified nurses is the key to providing high quality long term care. Yet, historically, the nursing home has been the practice setting of last resort for nurses. In fact, while there are more nursing homes than hospitals in this country and more nursing home patients than acute hospital patients, only 7.1 percent of all employed RNs work in nursing homes.

The current nurse shortage is handicapping our ability to provide adequate long term care. In a recent survey of our membership, 58 percent of all long term care facilities reported vacancies for RNs. One third of nursing homes indicated a need for one or more Rns just to meet current minimum federal standards for staffing. Seventy-eight percent of long term care facilities indicated a significant shortage of RNs in their service areas, and 79 percent reported a shortage of licensed practical nurses (LPNs). Recruitment has become much more difficult than in

the past, and almost one-half of our member facilities report it takes over three months to fill RN vacancies.

Most deficiencies found by state and federal surveyors inspecting nursing homes relate to lack of adequately prepared staff. Yet, staffing pressures will only worsen with pending nursing home reform legislation and revised conditions of participation proposed by the Department of Health and Human Services which will require nursing homes to meet higher nurse staffing levels.

The combination of staff shortages and high turnover has led to a reliance in some areas of the country on nursing pool agencies for temporary employees. In a recent Massachusetts study, almost two-thirds of long term facilities in the state reported they rely on nursing pools to cover RN vacancies. One third indicated they are forced to use them "frequently." Long term care providers have found that using temporary employees who are not familiar with the facilitity and residents compromises quality of care. Temporary nurses do not provide continuity of care, often have inadequate training, are more expensive, and are not often available for weekend and undesirable shifts. Clearly, nursing pools are not a viable replacement for qualified and trained staff that have a stake in the quality of care provided to residents. Alternatively, nursing homes, as well as hospitals, are looking to other countries with commensurate nursing education programs to recruit RNs to work in their facilititea, although it often takes two years for a foreign nurse to relocate in this country.

The future availability of nursing personnel is not promising either. The most recent report on nursing from the Department of Health and Human Services revealed that in 1983, 121,000 professional nurses worked in nursing homes, and it predicts

that in 1990, 500,000 will be needed. By the year 2000, over one million RNs will be needed in long term care facilities. Yet, all evidence points to declining enrollment in nursing programs, declining interest in nursing careers among college students, and a shrinking pool of females age 18-24 -- the population most likely to enter the nursing profession.

The etiology of our nursing shortage is complex. From our view, however, two major factors are paramount and must be addressed if we are to find workable solutions. First, health care, especially long term health care, is predominantly publicly financed. Federally- and state-imposed rates determine our parameters for nurses' salaries. These salaries are, by and large, seriously inadequate, especially for experienced nurses, and in view of the other more lucrative options open to nurses. Nursing homes, with their lower salary levels, have traditionally found it difficult to compete with hospitals. The explosive growth in alternative health care delivery systems and community-based treatment settings makes competiion for already scarce RNs even more intense.

Salary data provide insight into the recruitment problem. RNs in nursing homes earn an average of 23 percent less as head nurses and 19 pecent less as staff nurses that those in hospital settings. The laws of economics have not been repealed for health care. If we do not adequately compensate our professional staff, we will be without that professional staff to care for the elderly and chronically ill in nursing homes. As long as long term care providers are locked into historical rates set in a cost-conscious environment, we will continue to have difficulty attracting and keeping the most capable nurses. I am suggesting that the very principles of health care financing must be revised with an eye toward quality, not just budget consciousness.

Second, finances aside, we, as employers and consumers of health care, must treat nurses as valuable resources. We must give these professionals the respect they deserve and a supportive work environment in which they can practice to their potential. We must give them the resources needed to deliver quality nursing care. We must minimize paperwork burdens and non-nursing functions and let nurses concentrate on assessment of patient needs, planning, coordination and delivery of patient care.

Several legislative proposals have been offered this year to address the nursing manpower shortage. I applaud these efforts and, in addition, I would like to suggest other potential legislative initiatives for your consideration.

Legislation introduced by Senator Kennedy and passed by the Senate, S. 1402, and its House companion introduced by Congressman Wyden, has two especially attractive provisions. First, the bill establishes nurse recruitment centers where we can target junior high, high school, college and older candidates with information on the nursing profession and nursing education programs. Second, the bill would expand the valuable work of the Robert Wood Johnson Teaching Nursing Home Program and encourage schools of nursing to establish and nurture special efforts in gerontological nursing and nursing homes as a clinical setting.

Your bill, S. 1765, Mr. Chairman, is a logical complement to S. 1402. While we applaud the total bill, we are particularly encouraged by the special attention you rightfully give to the practice of nurse practioners in long term care facilities. These are exceptionally competent and skilled professionals who, unfortunately, have been discouraged from nursing home practices because of government-imposed barriers to their practice.

Your bill would eliminate these barriers and properly encourage greater use of nurse practitioners in nursing homes.

While I certainly support all public efforts aimed at increasing the overall number of nurses, there are certain measures that would especially help to relieve shortages in long term care.

Support for LPN Programs

Licensed practical and vocational nurses are the lifeblood of long term care facility nursing services. They are hands-on, bedside nurses that provide much of the direct patient care in nursing homes. We are alarmed at efforts to discontinue LPN educational programs and to limit the practice of LPNs and LVNs. We recommend public financial support of successful licensed practical-vocational nurse educational programs. We further recommend that federal statute and regulations not limit, in any way, the scope of service of these nurses. Rather, the governing of the practice of nursing should remain at the state level.

Permit Qualified Foreign-Trained Nurses to Practice in the U.S.

As an interim, temporary measure to meet nursing home patients' nursing needs, many long term care providers are looking outside the boundaries of this country for nursing staff. The barriers and red tape associated with recruiting foreign-trained nurses are formidable. AHCA respectfully requests consideration of policies which would streamline the entry of qualified nurses into this country. We are not suggesting waiving basic educational, testing or salary safeguards built into the process of utilizing foreign professionals. We are suggesting an examination of the guidelines and barriers to nurses from such countries as Canada, the United Kingdom and Ireland, where nurses receive comparable education and are interested in working in America.

Loan Forgiveness for LTC Nurses

Years ago, student nurses who received their education through the federal Nurse Training Act loan progam were able to cancel up to half of their student loans by working in certain clinical settings. We believe this idea should be renewed and aimed at practice in long term care facilities because of the special problems we have in attracting new graduates. This program would help the overall supply of nurses by supporting students for whom financial limitations pose a barrier to nurse education. It would help schools of nursing by helping to recruit additional bright candidates. And, I assure you, the financial incentive would benefit the patients and residents needing care in America's nursing homes.

The Need for LTC Clinical Practice in Nursing Education

The lack of involvement between schools of nursing and nursing homes is an important factor in the lack interest among nursing students in nursing home careers. When faculty members do not advocate the importance of gerontological nursing and nursing students have no clinical experience in long term care settings, it is rare that nursing students select nursing homes as their desired practice setting.

We advocate expanded federal funding of education programs that encourage clinical affiliations between nursing schools and nursing homes, from university baccalaureate degree programs to community college associate degree nursing programs. Nursing school affiliations would bring a new source of potential recruits to the nursing home setting because the familiarity of the setting from student experiences and greater professional visibility. They would also serve as important mechanisms for needed faculty development activities and increased program emphasis on gerontological nursing.

Mr. Chairman, I would just like to commend you for your timely hearing on the nursing shortage crisis. The availability of nurses is critical to the ability of nursing homes to provide for the present and future long term care needs of our elderly, and I look forward to working with you in your efforts to address this serious health care problem.

American Association of Colleges of Nursing
aacn One Dupont Circle • Suite 530 • Washington, D.C. 20036 • (202) 463-6930

Good morning. I am Dr. Nancy Greenleaf, Dean of the School of Nursing at the University of Southern Maine. I am pleased to present testimony before you today on behalf of the American Association of Colleges of Nursing which represents more than 400 university and college based baccalaureate and higher degree schools of nursing. Our association is deeply concerned about the current and growing nursing shortage and applaud your efforts to determine the nature of the problem and potential solutions.

During this morning's testimony I am sure you will hear many statistics that provide evidence of the serious nature of this problem. Our association has particular concerns about the shortage that our reports portend. For several years we have gathered information on student enrollments and graduations in baccalaureate and graduate nursing programs.

In the academic year 1985-86, baccalaureate programs experienced a 4.5% drop in enrollments. This was the first indication of a declining interest in nursing as a profession. In the academic year 1986-87, baccalaureate programs experienced a 12.6% decline. This second, more precipitous decline was the largest percentage decline in several decades. This year our association has just begun to analyze the data for student enrollments in baccalaureate nursing programs. Early indications

exist that a for a third year in a row, enrollments in schools of nursing will again show large drops.

A study recently commissioned by the American Association of Colleges of Nursing predicted the continuation of dropping enrollments in all types of collegiate nursing programs. Dr. Kenneth Green of the University of California Higher Education Research Institute studied career preferences of entering first time full-time college freshmen.

Dr. Green analyzed data regarding nursing as part of a larger study of American freshmen. Dr. Green traced career choices for nursing over a period of the last ten years. His findings indicate that within a two year span of time, from 1984 to 1986, the number of college freshman indicating that they expected to acquire a degree in nursing decreased by 50%. This number is truly astonishing.

The 50% decline in individuals indicating a preference for a career in nursing is representative of those individuals at the front of the educational pipeline. The effects of this decline will be felt in the years 1990 to 1992 when even greater drops in graduations from collegiate nursing programs will occur. So if we are currently extremely concerned about the availability of nurses to meet patient care needs today, the problem will only continue if strong action is not taken to address some of the reasons for the declining enrollments.

Only limited research on how individuals make career choices exists today. However, by looking at the changing career preferences of women many of us in nursing are able to draw conclusions as to why nursing is experiencing these declines. Nursing is a predominately female profession, and despite our interest in recruiting both males and females, societal views of nursing continue to perceive nursing as a career choice for women.

But women are no longer constrained by limited views of what is an appropriate career choice. I am sure you have each heard

the statistics which indicate that as enrollments in nursing have declined, the numbers of women enrolling in engineering, law, medicine, accounting, or business have skyrocketed. Young women today are seeking professions which they perceive as more likely to provide both prestige and monetary rewards. Many individuals do not perceive nursing as a career that is of high social prestige. Moreover, the salaries that nurses receive are often not reflective of the tremendous responsibilities and high level of education that nurses have.

Nurses who have finished a rigorous and intellectually demanding program of study for a baccalaureate degree in nursing receive an average starting salary of $20,000. The average beginning salaries for graduates of baccalaureate programs is comparable to the salaries paid many recent college graduates. However, the gap between beginning salaries and salaries for individuals with many years of practice and extensive education is only $7,000. Nurses working for many years can not expect to see the progressive salary growth that many other professionals such as engineers can expect. The diminishing returns are a major factor in selection of a career other than nursing.

So what are the solutions to this complex health care problem? For a lack of highly skilled and highly educated nurses to meet the increasingly complex needs of our population is indeed a major health care problem. The intensification of patient care needs in all health care settings demands the presence of the most highly skilled and educated nurses. And, nurses with baccalaureate or higher degrees are predominantly located in patient care settings that demand expert clinical skills.

A recent issue of Pediatric Nursing identified that over 50% of the readers of this journal were employed as staff nurses doing direct patient care. Of this group of staff nurses, 39.6% had bachelors degrees in nursing. 21.2% had masters degrees in nursing, and 3.2% had doctoral degrees in nursing. So almost 70%

of the staff nurses who subscribe to this journal have baccalaureate or higher degrees in nursing. Moreover, our association's research shows that over 85% of graduates of baccalaureate nursing programs are engaged in direct patient care in the hospital, nursing home or home health care setting.

The solutions to the complex problems surrounding the nursing shortage must be complex themselves. Simply providing support for individuals who are entering nursing education programs will not make the shortage disappear. This is not to suggest that educational support is no longer necessary. Rather, the costly nursing education experience must be assisted in new and creative ways in addition to improving the work environment for nurses. Our association would therefore like to commend you, Senator Mitchell, for your innovative and wide-ranging approach to the nursing shortage in S 1765.

The inclusion of initiatives to provide direct reimbursement for nursing services under the Medicare system is an indication of your awareness of the importance of nursing in the health care system. Nurses should receive direct reimbursement for the high-level quality care provided to the elderly or the disabled. The initiative to provide direct reimbursement to nurse midwives and pediatric nurse practitioners is a logical step in the direction of providing safe, cost-effective health care. In addition, the recognition that these providers are important members of the health care professions will improve perceptions of the value of nursing as a career choice.

Of greater importance to our association, however, is your awareness of the need to support the costs of clinical training for graduate nursing education. The shortages that exist for the basic level practitioner are also present for the advanced level clinician. The Fifth Report to the President and Congress by the Secretary of the Department of Health and Human Services predicted a shortfall of 200,000 nurses prepared at the advanced graduate level by the year 1990. This shortfall will increase to 335,000 by the year 2000. Coupled with the projected increases

83-151 O - 88 - 4

in an elderly population, these figures reveal a need to strongly support both graduate and undergraduate nursing programs.

The current medical education funding available through the Medicare system does provide support for many basic level nursing programs. However, when providers have attempted to engage in collaborative arrangements with academic institutions for the purpose of supporting clinical training activities for nurses, Medicare passthrough support has often been denied. Many hospital providers are aware of the positive effects which accompany clinical training for graduate nursing students.

Our association is engaged in a study of the costs and benefits of clinical training activities that clinical service agencies incur. Early data indicate that clinical service agency administrators recognize the beneficial aspects of having graduate nursing students in their service environment. Often, in addition to the obvious service provided by these registered nurse learners, additional services that the provider would be unable to make available are provided by the graduate student nurse. These services may be as simple as additional patient teaching or rehabilitation activities or may be as complex as system wide analyses of the patient care demands in a setting.

The faculty who accompany graduate nursing students to clinical service agencies also provide expert consultation regarding complex patient care problems. Yet, the faculty are not reimbursed by either the patients receiving the benefit of these services or the provider clinical agency. Instead, faculty salaries are exclusively provided by the academic institution in which the student is enrolled.

Many providers recognize the value of supporting these clinical training activities and provide resources to the academic institution and incur costs to assist this training. And if clinical service agencies incur costs in support of graduate nursing education, some relief in the form of Medicare support for graduate nursing education should be provided.

The justification for requesting this support is concerned with the fact that clinical training cannot occur in the absence of service to patients. The inclusion of practical patient care experiences is central to clinical education. The support of nursing education by a system of health care reimbursement designed to assist the elderly is appropriate. Nursing is an extremely important resource for care of the elderly. In addition, nurses with graduate clinical degrees are extremely responsive to the needs of elderly, rural or underserved populations. Advanced nurse clinicians are major providers of care for these groups. The University of Pennsylvania reports that approximately 70% of its nurse practitioner graduates are employed in urban settings working with populations below the poverty level. Support of the clinical training activities necessary to prepare these clinicians is an appropriate goal of the Medicare system of reimbursement with the potential to enhance significantly the health care status of these populations.

Our association recognizes the serious consequences of a nursing shortage to our nation's elderly and the health care needs of all individuals. We applaud your efforts and the Committee's efforts on behalf of our nation's health care needs. We support your efforts to introduce new and innovative solutions to the nursing shortage. Solutions to the shortage must include initiatives to improve the practice environment and enhanced support for individuals seeking a career in nursing.

In closing, we offer our support in developing additional solutions that will help all of us find answers with long term effects. Nursing recognizes its responsibility to assist in overcoming the problems identified. Our association is engaged in numerous activities to enhance recruitment into the profession. However, without your efforts to enhance the work and education opportunities for nursing, recruitment will be futile.

Prepared Statement of Christine Zambricki

I am Christine Zambricki, a Certified Registered Nurse Anesthetist (CRNA) from Michigan. I hold a B.S. degree in nursing and an M.S. in anesthesia. I am Administrative Director of Nurse Anesthesiology at Mount Carmel Hospital, Director of the Graduate Nurse Anesthesiology Educational Program at Mercy College in Detroit, and former member of the Government Relations Committee of the American Association of Nurse Anesthetists (AANA). I also am a member of the Michigan Board of Nursing. I speak on behalf of the American Association of Nurse Anesthetists, the national professional organization representing 23,000 CRNAs. We appreciate this opportunity to present testimony regarding the CRNA shortage, its effect on health care delivery, and to offer possible solutions to these problems and request your assistance in implementing them. As many of you on the Committee are aware, CRNAs administer between 50 to 70% of the anesthetics in this country working as employees of hospitals and physicians, or as independent contractors. About 40% of our members are hospital employees, 37% are physician employees, and 7% are self-employed.

Rural hospitals in the United States comprise about 30 to 35% of the hospitals in the United States, and the CRNA is often the sole anesthesia provider in these hospitals. Shortages of CRNAs could adversely affect the capability of rural hospitals to provide many of the health services that the population they serve have come to expect in their home community, close to family and friends. While rural hospitals are not structured to take care of all health needs that may arise in rural communities, they safely and competently provide many surgical and obstetrical services requiring anesthesia. In addition to often being the sole anesthesia provider in rural areas, many CRNAs provide anesthesia services in urban and suburban areas in all types of health facilities, including academic health centers, community hospitals, ambulatory surgicenters, and physician and dental offices equipped for surgical procedures. Because of the present shortage of CRNAs, CRNAs are working significantly longer hours to accomplish the required workload in these areas. This increases the cost of care while creating work conditions conducive to human error and patient injury due to provider fatigue. Other than anesthesiologists, there are no other health providers that may safely substitute for CRNAs in the workplace. In addition, since World War I, the U.S. military services have relied heavily upon nurse anesthetists for anesthesia services in peace and war, both at home and abroad. The shortage of CRNAs on active duty and in the Reserve components of the military has been cited as a major concern regarding medical readiness by the Defense Department by members on the House Armed Services Committee.

In the last two years, a pronounced shortage of CRNAs has become apparent in both the military and the civilian sector. This shortage has occurred at the same time that shortages in nursing and a large number of the allied health professions have become apparent. These shortages probably have many common causes which will be of long term consequence unless the Congress undertakes a review and assessment of why high school graduates are not electing to enter these fields and take appropriate action based on the findings. It is incongruous that there is a glut of physicians in this country and yet there are shortages of those nonphysician health professionals that are essential for supporting physician services. It is inexplicable that this nation has placed the major portion of its health education resources in preparing physicians who cost the most to educate, and whose services cost the most, when history demonstrates that lower cost alternative providers can be educated and provide many of those same services in a more cost effective manner working in collaboration with physicians.

The national shortage of CRNAs stems from four primary causes: (1) a decrease in the number of educational spaces for their preparation resulting from the loss of a large number of nurse anesthesia educational programs due to hospital concerns about educational costs in the prospective payment-DRG era; (2) the diversion of clinical training resources, formerly dedicated to nurse anesthesia training, by physician chairmen of Anesthesiology Departments in academic health centers for physician training in this specialty; (3) the ripple effect that the general nursing shortage is and will continue to have on the recruitment of nurse anesthesia students; and (4) the lack of adequate earnings and of an appropriate professional work environment for nurses and CRNAs.

1. The Lack of Education Funds

To become a Certified Registered Nurse Anesthetist, a professional nurse must have a baccalaureate degree in nursing or another appropriate field such as one of the basic sciences, have a minimum of one year's nursing experience in a critical care area, and have completed an accredited nurse anesthesia educational program of at least 24 months duration of advanced didactic education with appropriate clinical practicums. While in recent years many of these educational programs have moved into graduate educational frameworks within academic settings, many have remained hospital-based with academic affiliations. Regardless of whether these programs reside in hospital or university settings, hospital clinical facilities and clinical faculty are essential to the preparation of nurse anesthetists. Traditionally, therefore, hospitals have borne a major portion of the cost of nurse anesthesia education ever since formalized educational programs for preparing nurse anesthetists were established in the first two decades of this century.

The Prospective Payment System, enacted into law in 1983, and the efforts of some private insurers and corporations to reduce health costs through utilization of health

maintenance organizations, or preferred provider plans, have caused many of these hospitals to reevaluate the fiscal costs associated with the education of health professionals. Unsure of their financial future in the face of decreased bed occupancy and the prospective pricing of hospital care, a large number of hospitals have chosen to close their nurse anesthesia educational programs. Hospital concern about educational costs has been compounded by Administration proposals to eliminate funds for nursing educational programs and students and for restricting graduate medical education funds authorized under Medicare legislation to postgraduate physician education.

2. Diversion of Resources to Medicine.

In addition to hospital concerns about educational costs, some academic health centers have taken advantage of the increased number of medical school graduates and increased the size of their anesthesiology residency training programs at the expense of nurse anesthesia education. In some instances this has been accomplished through reducing the number of nurse anesthesia training slots in existing programs. In a significant number, it has resulted in eliminating these programs altogether. In 1982, nurse anesthesia educational programs graduated 1,107 nurse anesthetists; in 1986 that number had dropped to 722 principally due to program closures. As long as we were graduating between 950 and 1100 nurse anesthetists annually, no demonstrable shortage existed. But because in the last two years of number graduates has declined to the 720 to 750 level, we are seeing major shortages of CRNAs. There is currently no evidence that this trend is going to be reversed in the near future.

I would like to provide some specifics on program closures:

a. The so-called physician "glut" has given some of the leaders within the American Society of Anesthesiologists (ASA) hope of achieving a long held goal to make anesthesiology an all physician specialty. These leaders, working within ASA, the American Board of Anesthesiology, and the American Association of Anesthesia Academic Chairmen, have exerted pressure to reduce in size or eliminate nurse anesthesia educational programs in academic health centers where there are coexisting medical residencies. While citing a multitude of other reasons, nurse anesthesia educational programs at the University of Michigan, Johns Hopkins, Mary Hitchcock-Dartmouth Medical Center, Loma Linda, University of South Alabama Medical Center, and others have been closed by the Anesthesiology Chairmen in those facilities; the chairman either controls or exerts great influence over the clinical resources for training. The nurse anesthesia programs at the University of Michigan and at Johns Hopkins had been in operation for over 60 years. Examples of nurse anesthesia educational programs which have been reduced in size, some of which are experiencing CRNA staff shortages themselves, are North Carolina Baptist Hospital in association with Bowman

Gray Medical School, the Medical College of South Carolina at Charleston, University of Cincinnati Medical Center, Eastern Maine Medical Center, and Washington University in St. Louis.

b. Duke University closed its nurse anesthesia educational program at the same time it closed its undergraduate nursing program in about 1983 as a cost-saving measure. Even though Duke has significantly increased the number of medical anesthesiology residents it prepares, Duke is recruiting for 20 more CRNAs. Creighton University-St. Joseph Hospital closed their nurse anesthesia program but is now recruiting more CRNAs. Creighton is willing to pay a finder's bonus of $2000 and full relocation costs for the CRNA. Such measures are not unusual. It is clear that the closure of nurse anesthesia educational programs to prepare more anesthesiologists has not diminished the need for CRNAs. Salaries for hospital employed nurse anesthetists have significantly increased in many areas in this past year because of hospital concerns with both retention and recruitment of CRNAs. In North Carolina alone, there are approximately 70 CRNA vacancies. Kaiser-Permanente of Southern California is recruiting for 25 additional CRNAs. In fact, advertisements for nurse anesthetists have quadrupled in the past year, as has individual recruitment mailings to CRNAs. At the 1987 AANA Annual Meeting in Cincinnati, physician groups, institutions, and the military services made major recruiting efforts.

c. The nurse anesthesia educational program at the University of Texas Health Science Center experienced a slightly different problem. While the Anesthesiology Chairman did not have the authority to close the program, he denied access to the students within that program to the University's primary teaching hospital. While the nurse anesthesia faculty were unable to resolve this problem at the local level, the University of Texas Board of Regents has recently intervened and ordered that the program be allowed to enroll up to 12 students yearly and have access to the primary clinical site. However, it required going outside of University channels to get to the Board of Regents and almost two years for this to be achieved.

The impact of the increase in anesthesiology residency training reported by the ASA and reflected in nurse anesthesia educational program closures or reductions has not resulted in the elimination of CRNA spaces in the work force, as might have been expected, but rather has increased the need for CRNAs. We believe the ASA's goal to eventually substitute anesthesiologists for all CRNAs is unwarranted, and certainly not in the best interest of health care in this country, particularly in an era of cost containment. Such substitution will cause an increase in costs for anesthesia services to beneficiaries and third party payers without any evidence that it improves quality. Studies published to date show no significant differences in the outcomes of anesthesia care regardless of whether the provider is an anesthesiologist or CRNA.

Further, there is evidence that the increase in number of anesthesiologists being prepared may not be having the quantitative effect that ASA is claiming. In the early 1970s, foreign medical graduates (FMGs) made up nearly 60 percent of the anesthesiology residents in training. FMGs now represents only about 10 percent of the anesthesiology residents. It is true therefore, that recruitment of American graduates into anesthesiology residencies has about tripled. But many of those graduates replace the FMGs that were previously in these residencies. In 1972, anesthesiology residency training was three years in length and there were 2,268 total residency spaces, or 756 spaces per year. Today, the residency lasts four years and there are a total of 3900 residency spaces. If filled, the residencies will graduate only 219 anesthesiologists per year more than they were capable of graduating in 1972. With current opportunities for subspecialization in anesthesiology, all of these graduates will not be reflected in operating rooms or ambulatory surgicenters. This may be the reason why the decreased number of graduates from nurse anesthesia educational programs in 1985 and 1986 precipitated such an immediate shortage.

3. Ripple Effect of General Nursing Shortage -- The Need for Economic Incentives and Professional Autonomy

The current nursing shortage affects recruitment of new students into nurse anesthesia programs. Unless actions are taken to recruit more students to enter professional nursing, there will be fewer nurses in critical care, the area from which nurse anesthesia draws its students. This is the reason we proposed early in our testimony that a study be undertaken by the Congress to look at why individuals do or do not choose nursing as a career, and the extent to which legislative and regulatory influences have served as disincentives for creating the kind of work environment conducive to attracting individuals into nursing. We believe that nursing and nurses through being paid less than their true value have been utilized for many years to subsidize health care in this country, just as women in the work force have been utilized in general to support the economic interest and profits of other industrial fields. The increase in opportunities for women in the traditionally male domains of medicine, law, and business are taking their toll on those professions that have traditionally been comprised of women. Women are seeking professions in which there is opportunity for equitable income for the workload performed, and want to feel in control of their work. If nursing, therefore, is to be a viable profession for bright, intelligent, caring high school graduates, barriers must be removed which impede nurses from being paid on an equitable basis for their services, from having autonomy and control over their practice, and from having a significant role in future health planning and policy decisions. While the federal government cannot achieve this solely through its own resources, we believe there are means by which it can significantly influence the removal of such barriers wherever they exist. Two specific examples of adequate pay and

professional autonomy problems in anesthesia affecting CRNA supply and geographic distribution are the fee schedule to be developed by the Health Care Financing Administration (HCFA) for CRNA services and the recent Joint Commission on Accreditation of Hospitals (JCAH) decision to require greater control of CRNA practice than existed under prior standards. If the CRNA fee schedule is not a fair reflection of the value of CRNA services, it will be difficult to recruit into the field and hospitals and physicians will have no incentive to employ them. The fee schedule must create incentives for utilization of CRNAs while remaining budget neutral. Rural areas will have much to lose if the national fee schedule is not reasonable. Similarly, recent House Committee action reduces incentives for physicians to employ and utilize nurse anesthetists.

The JCAH problem involves new standards for hospitals which may foster, without more clarity, all CRNA services to be provided under the direction of anesthesiologists. They also eliminate existing standards which clearly delineate broad CRNA roles in the delivery of anesthesia care.

RECOMMENDATIONS:

Our recommendations for resolving some of the nursing and nurse anesthesia shortage problems are as follows:

1. Congress should immediately consider making a review and assessment confirming the reasons why high school graduates are not choosing nursing as a career and determine to what extent federal and state statutes and regulations serve to create unwarranted disincentives for choosing nursing. Such a study should determine needed actions for long term resolution of the nursing shortage and serve to maintain a nursing work force essential to meet the health care needs of this country.

2. Nursing must be given a fair portion of the federal fiscal resources available for health professional education. This may mean diverting funding from physician training. This is justifiable given the widespread concern that there is a physician "glut." Under Medicare legislation this could include increased assurance to hospitals that they will receive appropriate funding for nursing educational endeavors as a part of the Graduate Medical Education Pass-Through. This would be particularly beneficial for nurse anesthesia educational programs.

3. There is a need for increased funding of nursing and nurse anesthesia education to permit:

a. Additional funding support to nursing education and nursing students in general.

b. The development, implementation, and/or expansion of nurse anesthesia educational programs. Some interest is being expressed by academic and other types

of medical centers that have not previously had nurse anesthesia educational programs. Further, some programs are amenable to expansion with additional clinical affiliates if additional faculty can be acquired. Such funding should be available for all types of nurse anesthesia educational programs.

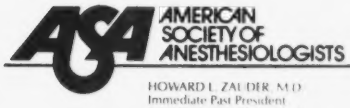
c. Additional support for nurse anesthesia students, and for the preparation of CRNA faculty, is badly needed. Unlike many graduate programs, the academic and clinical workload associated with nurse anesthesia education precludes students from working on a part-time basis to the extent necessary to cover their living and educational costs.

4. There should be provisions created which would deter hospitals which receive Medicare educational funds from denying the availability of clinical training resources to nonphysician providers on the basis of their nonphysician status where both physician and nonphysician programs exist or are being developed. In other words, there should be some type of disincentive in Medicare payment to hospitals who permit physician chairmen of departments to deny or reduce clinical access to nonphysician students in approved or accredited educational programs.

5. Finally, if the Joint Commission on Accreditation of Hospitals (JCAH) is to continue to be identified in Medicare statutes for purposes of using its accreditation as equivalent to that of the Department of Health and Human Services for Medicare funding, the Congress should undertake to authorize a program review of JCAH to determine whether its structure and decision making body adequately reflect the professions and the public affected by its accreditation, and whether its standards and accreditation process is fair and reasonable based on concerns of quality, costs, and the needs for professional personnel. Nursing, which represents the greatest number of employees and health professionals working in hospitals, is not represented in its own right in the decision making body of JCAH, and has been denied such requests on a number of occasions.

We thank you for this opportunity to present testimony before this committee. We understand the dilemma you face in making choices about health care, health provider education, and their costs, in a time of increased concerns about the federal deficit. We believe changing some of the priorities in health education spending could result in meeting some of nursing's needs without increasing the overall cost to the federal government. Further, we recognize the problems you may have politically in making such choices in realignment of priorities. But we would ask you to remember a statement made by Dr. John Knowles, a physician, when writing about postgraduate medical education in 1968. He stated that at the time of writing, it took about 15 other health personnel to support each physician, and that by 1975, he was expecting that number to rise above 20. If health care costs are to be

contained, the federal government should take great care that it is not increasing these costs exponentially by placing the bulk of its money on educating an excess of physicians but rather look to see what appropriate health professional mix is needed to accomplish the greatest workload in a cost-effective manner. We look forward to working with you to resolve the problems associated with the nursing and nurse anesthesia shortages as well as assisting you in finding means for containing health care costs in the future.



HOWARD L. ZALDER, M.D.
Immediate Past President
State University of New York
Health Science Center at Syracuse
Syracuse, New York 13210
(315) 473-4720

December 7, 1987

The Honorable George J. Mitchell
Chairman, Subcommittee on Health
1706 Senate Dirksen Office Building
Washington, DC 20510-1902

Dear Senator Mitchell:

I write to follow up on our conversation of Tuesday, November 16, concerning the testimony presented by the American Association of Nurse Anesthetists (AANA) before your Subcommittee on October 30, 1987. I have the following comments:

Anesthesia Care Demographics: In its statement, the AANA asserts that nurse anesthetists administer between 50 to 70% of all anesthetics given in this country. The statement also asserts that 30 to 35% of all hospitals in the United States are rural in nature and that CRNA's are often the sole providers of anesthesia care in these hospitals.

Combined, these assertions represent a rank overstatement of the role of CRNA's in the delivery of anesthesia care. Although CRNA's participate in the delivery of perhaps 50% of anesthetic procedures annually, their services are predominantly--according to both AANA and ASA data -- medically directed by anesthesiologists. Moreover, only eight percent of all surgery in the United States is performed in rural hospitals and even in those rural hospitals where no anesthesiologist is present, CRNA services must be and are medically directed by a physician.

CRNA Education Programs: The AANA asserts, and I agree, that there has been in recent years a significant decline in the number of nurse anesthesia education programs. The AANA fails to note, however, that in many instances this phenomenon is a reflection of the tightened accreditation standards put into place by the AANA itself a few years ago. And I vigorously dispute the AANA's bold assertion, for which there is not one shred of evidence that the decline in CRNA programs has resulted from a conspiracy among the leaders of organized anesthesiology.

The fact is that in the past several years, there has been a decline in enrollment at undergraduate schools of nursing, with

the result that the pool of graduate nurse candidates for CRNA education programs has also declined. In major part, I believe, these declines are a reflection of the changing professional goals of high school and college students: in 1987, for the first time, more women were enrolled in the first year of medical school than enrolled in nursing schools.

It is also certainly the fact at some individual institutions, CRNA programs have been constricted by virtue of the increased demands of anesthesiology residency programs. The explosive increase of medical knowledge in our specialty has necessitated increasing from three to four years the duration of accredited anesthesiology residencies, placing pressure on finite institutional teaching budgets and capacities. All anesthesia education programs have been impaired, moreover, by the major shift in the surgical patient population to ambulatory facilities, with the resultant loss in available teaching opportunities in the hospital setting.

Anesthesiologist Education Programs: The AANA statement contends in essence that current anesthesiology residency programs may not be increasing the member of physicians trained in the specialty, in that the programs are merely training U.S. physicians in the place of foreign medical graduates. The facile, unsupported conclusion is belied by ASA's own membership statistics: in 1970, ASA had about 10,500 members, but by 1987 that number had risen to 24,500; anesthesiologists certified by the American Board of Anesthesiologists have risen in number from 5163 in 1970, to 14,885 today.

The AANA also suggest that subspecialty training of anesthesiologists will impair physician coverage of hospital operating rooms and ambulatory surgical facilities. In fact, only 293 anesthesiologists have been certified in Critical Care Medicine; the remaining highly skilled anesthesiology subspecialties remain available to provide even better anesthesia care to surgical or obstetrical patients.

Nursing Shortage: ASA fully supports the view that every effort, including financial incentives, must be made to increase the attractiveness of primary care nursing. Just as there is precedent for channelling physicians into the primary care medical specialties, so also is it desirable to create opportunity for nurses who will provide patient care at the bedside and in ambulatory facilities.

It does not necessarily follow, however, that incentives are required or desirable in order to channel nurses into CRNA training. CRNA's are certainly already among the highest paid nurse practitioners, and unless it can be demonstrated that a serious shortage exists in personnel to provide quality anesthesia case in this country -- and I am not aware of data supporting this conclusion -- I have serious doubt that the expenditure of federal tax dollars is justified for the promotion of so narrow a nursing specialty.

I appreciate the opportunity to offer these comments, and express the hope that they can be included in the hearing record.

Very truly yours,

Howard L. Zauder, M.D.
Immediate Past President

COMMUNICATIONS

AMERICAN ASSOCIATION OF CRITICAL-CARE NURSES

President
President-elect
Treasurer
Secretary
Directors
Executive Director

November 24, 1987

The Honorable Lloyd Bentsen
Chairman
Senate Finance Committee
United States Senate
205 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Bentsen:

On behalf of the more than 57,000 members of the American Association of Critical-Care Nurses (AACN), we would like to take this opportunity to submit post hearing testimony to the Senate Finance Committee on the nursing shortage. AACN, as the largest specialty nursing association in the world, appreciates your concern about the growing nursing shortage. As an association, we are deeply concerned about recruiting critical care nurses.

AACN believes that the hearings held on October 30, 1987 were a reflection of an ever-increasing appreciation of nursing's critical participation and relationship to the health care industry's ability to provide health care to the nation. Recent television, radio and newspaper reports demonstrate that the public, media, physicians, most health officials and even industry administrators agree that a critical nursing shortage exists. There is even agreement about the cause for the shortage: low salaries, lack of prestige and control of nursing practice and decreased enrollment in nursing programs.

The latter has been spurred by increased career opportunities for women. Nursing still remains a profession dominated by women; only 3% of all nurses are men. Several universities recently closed their nursing schools due to low enrollment. Counselors and parents are steering articulate high achievers into medicine, law and engineering rather than to nursing.

83-151 0 - 88 - 5

IMPACT OF NURSING SHORTAGE

Health care leaders predict that by the year 2000 the hospital of the future will be one large intensive care unit. The complexity of hospital-based medical procedures and equipment, the rapid growth of health maintenance organizations, urgent care centers, surgicenters, corporate wellness centers, and other outpatient facilities and the needs of nursing homes and health programs will spur the predicted demand.

It is expected that the demand for critical care nurses will increase as a direct result of Medicare's prospective payment system. Data indicate that hospitals are building new critical care units or increasing beds in existing units. The advances in medical technology and developments in transplantation medicine require the services of critical care nurses. The fast-evolving, increasingly invasive technology of critical care and trauma care will increase the demand for critical care nurses.

Additionally, as a result of technological advances and changes in medical payment systems, patients with increasingly difficult health care needs are being cared for outside traditional in-hospital settings. Home health agencies are recruiting nurses with critical care experience to care for patients who are ventilator dependent, have subclavian or central line catheters and require parenteral nutritional support. The Labor Bureau predicts that more registered nurses will be required for technologically demanding but "generalist" responsibilities in the rapidly growing outpatient sector. DHHS also predicts that by 1990, the U.S. will face a shortage of 390,000 nurses.

Without an adequate supply of nurses with the multifaceted requisite skills, we are concerned that the trend toward substitution of trained non-nurse technicians for professional nurses will increase. It appears that hospitals are already hiring technicians and physician assistants at a robust pace. Although such technicians can perform technical tasks, they cannot practice nursing, this means that patients will not receive the benefits from quality care provided by the multifaceted professional registered nurse.

The professional nurse with critical care experience can provide comprehensive quality care. Lifesaving decisions can be made and immediate care given because such nurses are able to assess the patient's total health care needs. Increasing reliance on technicians who provide substitute care for nurses

can only result in fragmented care, delayed decision making and compromised patient care.

The undeniable increase in patient acuity that is seen in the inpatient critical care units, creates a greater requirement for the knowledge and skills of professional critical care nurses. In settings other than traditional critical care units, the demand for nurses with a knowledge of the myriad of patient problems resulting from complex technological support is great. Patients previously seen in critical care units are now being cared for in general medical-surgical units.

Paralleling the impact of advances in medicine, the increasing sophistication of nursing science has also influenced the complexity of nursing care for many groups of patients. Consider, for example, the changes in preoperative patient preparation, which once was limited to an antiseptic solution (Betadine) shower and perhaps a shave. Now preoperative preparation routinely consists of individualized teaching protocols that require greater nursing assessment, knowledge, skill and time. As we elicit greater understanding and knowledge through nursing research, our nursing care becomes continuously more complex and individualized.

The trends and advances in nursing and medical science, in combination with the greater numbers of elderly in our institutions, create a net result of more complex and intense patient needs. The impact on nursing resources is profound. There is a demand for more intense nursing care although fewer resources are available.

Advances in medical science and technology have compounded the problem in that increasing complex treatment modalities have increased the demand for critical care nursing services. The recent advances in organ and tissue transplantation is just one example. Both recipients and donors of organs require critical care nursing. Groups of patients who otherwise would not have required critical care nursing assessment and interventions are now being seen in critical care units.

Despite the expanded professional skills the physical demand of nursing should not be discounted. Nurses continue to spend a considerable amount of time walking hospital corridors, lifting heavy patients, pushing gurneys, tending to mountains of paper work, and coping with the human suffering and frequent

emergencies that arise in their daily work and are faced with a constant potential for exposure to infectious, chemical, and physical hazards.

INDUSTRY SOLUTIONS

In the past, the predominant solution to a shortage has been to require the nursing staff to "work harder" or "do more with less." Currently, the concept of nursing productivity is being examined by many more nurse administrators. However, increasing productivity and merely requiring critical care nurses to work harder will not resolve the imbalance between patient needs and nursing resources.

Another solution is to offer bonuses to increase recruitment of nurses. However, this is only a short term or "band aid" approach. Once the nurse has received the bonus and satisfied work experience requirements, there is no incentive to remain. Another hospital with a more attractive and lucrative "carrot" will lure the nurse away and benefit from her experience. Because the costs of orienting a critical care nurse are estimated at $10,000, hospitals must address the problem of retention as well as recruitment.

Both the hospital and nursing home industry have acknowledged that nurses deserve more pay but unanimously agree that they are unable to reimburse nurses more adequately under the current prospective payment system. Despite Gramm-Rudman, federal hospitals such as the Veterans Administration (VA) and the National Institutes of Health recently increased the pay of nurses and are attempting to correct salary compression. The starting salary for a staff nurse employed by a hospital averages $20,340; the average maximum salary, which is reached after 10 years, is $27,744. Although entry level salaries are acceptable, compression of the wage structure creates major retention problems in the nursing profession. Given the skill, effort, autonomy required, decision-making responsibility, and working conditions of nurses, such compensation is neither attractive enough to lure new recruits nor competitive enough to retain nurses with years of education and experience.

The recruitment and retention of nurses at individual hospitals is only part of the problem. For the first time, almost 80% of all nurses are employed. As we have stated, declining nursing student enrollment increase the problem. To increase the pool of nurses available for employment, those of us in nursing must increase the opportunity for new recruits to enter into the profession. An executive for a Minneapolis supplemental staffing agency said it best: "When you

put an ad in the paper that says you're willing to pay $22.50 an hour for CCRNs and your phone doesn't ring, you know there's a shortage."

PROFESSIONAL SOLUTIONS

Studies of nursing practice and education provide some idea of the steps that need to be taken to reduce or eliminate the nursing shortage problem. Briefly, they are that: 1.) nursing should be involved in all aspects of decision making in health care institutions that relate to patient care issues; 2.) the nursing practice environment should be conducive to collaboration among all members of the health care team; (3) salaries for nurses should be commensurate with levels of responsibility and experience. Unfortunately, little progress has been made to implement these key recommendations.

The difficulties of recruiting nurses into the profession and retaining nurses in critical care have been identified by AACN as a major trend that adversely affects critical care nursing practice and quality of care delivered to the consumer.

AACN recognizes that career choices for today's young people are more diverse than ever before. Creative and innovative solutions must be found to make nursing an attractive and rewarding career choice.

The critical care nursing shortage is resulting in mandatory overtime (leading to increased stress and resignations) and closure of critical care beds and, in some cases, entire critical care units. A plan to alleviate one of the major issues affecting critical care nursing - retention and recruitment of nurses - was unveiled during AACN's 1987 National Teaching Institute.

This year, we are calling on all of AACN's 57,000 members and 227 chapters to help us in convincing the American public that critical care nursing is the career choice for the future. The AACN Board of Directors has adopted "Critical Care Nursing: The Career Choice For The Future" as AACN's theme for FY88.

AACN's program includes:

- A study to establish a data base on manpower in critical care. Results of the study will provide data to substantiate and quantify the nursing shortage, help hospital administrators deal with the nursing shortage and assist lawmakers as they consider legislation such as the Nursing Training Act.
- A task force to evaluate compensation and its relationship to the delivery of care.

- o Theme posters, brochures, and videotape programs for members and chapters to use in discussing critical care nursing with various audiences.
- o Educational brochures, videotape programs, and posters for high school and grade school students.

AACN believes that the nursing profession must actively participate in recruitment in order to assure a future supply of nurses.

LEGISLATIVE SOLUTIONS

AACN believes that key initiatives addressing the nursing shortage should be initiated by the nursing profession in consultation with leaders within the health care delivery systems. There are, however, important strategies that can be implemented only through legislation and/or health policy changes.

There are a number of legislative proposals currently under consideration by Congress that address the nursing shortages and/or the ability of the nursing profession to provide its services outside the hospital setting. AACN, therefore, urges you to consider supporting the following Senate bills:

S. 1402

S. 1402, the "Nursing shortage Reduction Act of 1987" was recently passed in the Senate. This legislation would provide $5 million to the Secretary of HHS to: 1.) establish an advisory committee to address the nursing shortage, 2.) provide grants for innovative hospital nursing practice models to make the hospital nursing position a more attractive career choice, 3.) provide funds for demonstration projects designed to improve long term care practice and 4.) provide funding for model professional nurse recruitment centers.

The Nursing Shortage Act of 1987 is a beginning step to confront the current nursing shortage. AACN recognizes, however, that nursing professionals and associations must actively develop solutions to positively influence recruitment into the profession.

S. 1765 - The Nursing Manpower Shortage Act

We would like to echo the support of other nursing organizations regarding S. 1765. AACN believes that this bill will do much to focus national attention on the need for long-term positive solutions to the nursing shortage issue.

Section 2 of the bill establishes a demonstration authority for community nursing organizations. This provision has been incorporated in the Finance Committee's reconciliation package, and we are quite pleased by this action. By

allowing nurses to establish these organizations and receive payment for their services, which they do not receive under current law, we believe that the number of nurses willing to remain in the profession will greatly increase. Medicare payment policy, which refuses to recognize nurses as reimbursable providers, is another major reason for the shortage. The willingness of the federal government to recognize and pay for the services of nurses still greatly enhances the attractiveness of nursing. We would ask, however, that the committee accept the House Energy and Commerce provision, which is a complete authority for the establishment of community nursing organizations, rather than a demonstration project.

Section 3 of the bill will allow nurse practitioners and clinical nurse specialists to certify and recertify Medicare patients in nursing homes. Allowing nurses to certify the need for care and paying them for that service, will provide nurses with another attractive career option. This provision will not increase health care costs, but will increase access to care in facilities and provide an incentive for nurses to enter the field of geriatrics. We commend the chairman for inclusion of this provision; we understand that it may be offered as a floor amendment when the Senate debates the reconciliation legislation.

Section 1 of S. 1765 envisions an expansion of the graduate medical education pass-through for the clinical training of nurses. Under current law, only programs supported and operated by hospitals are eligible for payment under this program. We believe this to be an artificial limitation that ignores recent trends in nursing education.

Increasingly, nurses are receiving their education in collegiate schools of nursing. Permitting additional institutions to develop clinical education rotations for nurses in cooperation with accredited nursing education programs would benefit not only the institution through the patient care provided by student nurses, but may also encourage nurses to practice in such institutions after their education is completed. Such a program would also help to bring advancements in nursing practice more rapidly to the bedside through the collaboration of faculty from the educational program and nurses in clinical practice in hospitals.

environment. However, limiting the number of students based upon a variety of factors, such as location (urban/rural), specialty (critical care, operating room) or type of degree (graduate), could limit the financial burden of the program. We would like to work with the committee to formulate such a proposal.

S. 1833

Our review of this most recent legislation, the "Nursing Practice and Patient Care Improvement Act of 1987," indicates increasing congressional awareness of the nursing shortage issue and the need for innovative cures.

CONCLUSION

AACN believes that a recent study by the American Academy of Nursing and the American Hospital Association best articulates the following reasons for the shortage: financial rewards that are not commensurate with responsibility; opportunities for upward mobility are lacking; nurses have insufficient authority and autonomy; work demands are increasing because of rising severity of illness; and nurses are not given the opportunity to participate in management decisions regarding nursing practice standards and support services.

Critical care nurses are on the front lines in delivering quality health care, combining skill and education with caring and understanding. The current shortage of critical care nurses is significant and without our collaborative efforts, solutions will not be identified. Your continued support of national, industry and professional efforts to correct the nursing shortage is a positive step toward long-term solutions to the nursing shortage. AACN, through its 57,000 members and over 227 chapters, is committed to assisting you in your legislative efforts. Together, we can have a positive influence on the quality of health care delivered to the American consumer.

Thank you for giving us the opportunity to submit this testimony.

Sincerely,

Jeanette C. Hartshorn, RN, PhD
President

Senator George Mitchell
Chairman of Senate Finance Subcommittee on Health

Dear Senator Mitchell:

We welcome the opportunity to make our views on the nursing shortage known. As staff nurses; the primary providers of health care to hospital patients, we are on the front lines of this crisis.

Recently, we returned from the New York State Nurses Association annual convention in Buffalo, New York. While there it was immediately apparent that nursing leaders, many of whom are administrators and educators, are focusing their efforts on passing BSN entry level into practice.

The majority of " front line " nurses there were amazed at how little attention was given to the nursing shortage. The following thoughts are a consensus of opinion of the many nurses we have spoken with:

1) While BSN entry level into practice may be an accomplishment in the next century, it is at this time a suicidal goal for the nursing profession.

   To close all diploma and associate degree programs will seriously limit the number of people entering nursing. As graduates from a diploma school, practicing more than twenty years in nursing, we have not seen any better care provided to a patient because the nurse had a BSN. In fact, in some cases, they are less clinically prepared.

   All avenues of education require the same determining factor to practice nursing, i.e. A licence obtained by passing a State Board examination. All nurses take the same examination. We urge all legislators to vote NO on any BSN entry level into practice proposal.

2) Help change the working conditions of nurses so that they can work in an environment providing good patient care. Nurses are leaving the profession because of intolerable working conditions. These conditions are unsafe for both patients and nurses.

   Legislators can improve safe care by requiring Health Care Facilities to mandate a realistic nurse/patient ratio. Guidelines that stipulate " a sufficient number of nurses", is vague and an abdication of responsibility. Standards of care must be established and monitored.

3) Reimbursement to Health care facilities must be increased so that nurses can be recruited. Hospitals cannot exist without these basic health care providers.

   Salaries must be increased, thereby retaining people in the profession who are moving to more lucrative careers.

4) National Legislature and nursing leaders can co-sponsor a campaign to provide a proper image of todays nurse. This would educate the public and encourage young men and women to enter the profession.

The future of nursing is at a crossroads. This is not the first time that the leaders have had to rush to catch up with the troops.

Sincerely
Judith Belliard
Amelie Gladman

Judith A. Belliard R.N.
Amelie Gladman R.N.

DRAKE UNIVERSITY

MARY C. HANSEN
DIVISION OF NURSING

221 OLIN HALL
DES MOINES, IOWA 50311

DEPT. 515 / 271-2830
OFFICE 515 / 271-3161

November 23, 1987

Commitee on Finance
United States Senate
205 Dirksen Building
Washington, D.C. 20510

Dear Committee Members,

We are writing in response to your call for written statements regarding the subcommittee hearings on the current nursing shortage crisis which is adversely affecting the health care of all Americans, but in particular, the elderly who consume a disproportionate share of health care services. We, the undersigned graduate nursing students, share this concern and wish to offer testimony in favor of increased funding for elderly health services as well as increased funding to recruit and educate qualified individuals into the nursing profession.

Recent testimony by Kevin L. Morrisey, Director of Communication for the National League for Nursing, to the Senate and House Appropriations Committee, highlighted the health care plight of the elderly that will necessitate an increased supply of nurses. He quoted the 1986 Institute of Medicine Study, "Improving the Quality of Care in Nursing Homes", which projected that there will be an increase of 68% in the number of residents receiving care in nursing homes between the years 1980 and 2000. This study also projected an additional 33% increase by the year 2020.

Over a decade ago a World Health Care Organization Committee on Planning and Organization of Geriatric Services, recommend that societies consider the elderly a vulnerable group with a multiplicity of physical and mental chronic health problems. The committee further asserted that there was a need for holistic approaches to these problems. The profession of nursing has historically provided the unique services necessary to meet the challenges presented by these problems. These unique areas of expertise include: health education and counselling, and assessment of the client's life dynamics as a basis for preventive health care. Nurses are in the best position to accomplish this since they maintain regular contact with the client and can therefore detect problems before a more serious condition develops. This can not only mitigate deterioration of the client's health status but can also be a cost effective mechanism to reduce dollars that need to be spent for preventable health problems.

In order to meet these challenges facing the future of quality health care delivery to the American public and particularly the elderly, nursing must be involved as never before. However, according to the National League for Nursing, a 10% decline in enrollment in nursing educational programs occurred between 1983 and 1985. The situation does not appear improved and in fact has worsened. The Journal of Professional Nursing refers to a Health and Human Services report that suggests a potential 50% shortfall in the supply of R.N's over the next five to ten years. This same issue also reported a 70% decline in the proportion of freshmen women interested in nursing careers.

Government funding to support nursing education has precipitously declined. The constraints imposed by this decline impact the nursing shortage by limiting nursing education recruitment of qualified applicants as well as the hindering the development of gerontological nursing courses. Even more critical is the fact that too few nurses are currently caring for the elderly in nursing homes. Roncoli and Whitney state that only 15% of personnel who care for the elderly are R.N.'s and only 42% of skilled long term care facilities have 24 hour R.N. coverage. With the increase in longevity and the concomitant increase in chronic illness this is a critical deficit.

We strongly support your committee's efforts to deal with this issue and welcome the consideration being given to this critical situation.

Sincerely,

May Hansen RN, (Instructor)

Jane Hutton RN
Mary J Brown Co LPN
Margaret Cooper R.N.
Kimberly Turner LPN
[illegible]
Sue Farnham RN
Vicki Bonett RN
[illegible]
JoAnn Jensen RN
Darlene Shipp, R.N.
[illegible], RN
[illegible]

Sylvia Kinzer Blanchfield R.N
Judith K. Donahue RN
Anita Radloff RN
[illegible]
[illegible]
Cheryl L. Barnes RN, BSN
[illegible]
[illegible]
Marjorie A Blake
Karen J Heistand

Geisinger

November 25, 1987

Committee on Finance
United States Senate
205 Dirksen Building
Washington, D.C. 20510

Geisinger is pleased to have the opportunity to comment on the Mitchell Bill which addresses the nursing shortage.

The Geisinger health system includes ten (10) wholly-owned or controlled entities dedicated to health care and health care management. Attached as Appendix A is a brief synopsis of these Geisinger entities.

Geisinger's two hospital facilities--the 569 bed Geisinger Medical Center (GMC) a rural referral tertiary care center located in Danville, PA. and Geisinger Wyoming Valley Medical Center (GWV), a 230 bed-community hospital in Wilkes-Barre, PA. annually record more than 200,000 combined patient days.

Geisinger serves primarily a rural area, characterized by an aging population with higher unemployment and lower per capita income as compared to other counties in the state in general. These demographic characteristics appear to be similar for the next five years in the Geisinger service area, with most of this increase attributable to the 65 and older age group.

According to the American Hospital Association statistics, the nursing shortage in America is a reality. The vacancy rate for registered nurses in United States hospitals more than doubled last year, from 6.3% to 13.6% in 1986. This shortage is different and more serious than previous ones because it involves all types of nurses in all kinds of hospitals and in all regions of the country.

Nursing student enrollments throughout the nation are down 9% in 1987 according to National League for Nursing data, and double digit declines are projected for the rest of the decade. Equally disturbing is a 26% decline in applications to R.N. educational programs over the last three years. Based on these trends, an anticipated 15% decline in graduates is predicted from 1987 to 1990.

The dimensions of the problem become particularly graphic when one considers the escalating care needs of the rapidly growing elderly population. By the year 2020, the elderly -- the fastest growing segment of which is the over 80 population -- are projected to number 52 million, comprising 21% of the population.

The Geisinger Medical Center School of Nursing was established in 1915. A total of 2786 graduates have completed the program. The current total enrollment in the two-year diploma program is 162. Thirty advanced placement students will enter in January, 1988 and the total will increase to 192. The student population is 57% non-traditional and 90% of the students receive some form of financial aid. Graduates of the program remain in the five county area, supplying nurse manpower for community hospitals, long term and extended care facilities. A large portion of the graduates remain in Pennsylvania and many practice at the Geisinger Medical Center.

	TOTAL GRADUATES	REMAINED AT GMC	REMAINED IN PA.
1985	84	28 (33.3%)	66 (78.5%)
1986	81	40 (49.3%)	69 (85.0%)
1987	79	32 (40.5%)	72 (91.0%)

Strategies to increase the nursing applicant pool in the future should include:

1. Federal support through the graduate medical education funds to basic RN programs must continue at a rate of at least 75% to offset program operating costs for hospital based programs.

2. Hospitals should receive federal reimbursement for all basic nursing students affiliated at the hospital.

3. Federal nurse traineeship grants need to be extended to basic nursing students, not just graduate or post graduate nursing students.

4. Federally sponsored demonstration projects must also focus on acute care rather than just long term or community home care setting.

5. Current proposed legislation must address all nursing education programs and acute care hospital settings, not just collegiate programs and community care settings.

Sincerely,

F. Kenneth Ackerman, Jr.
Senior Vice President and
Administrative Director

FKA:na

APPENDIX A
GEISINGER SYSTEM DESCRIPTION

GEISINGER FOUNDATION

Geisinger Foundation, a not-for-profit corporation, is Geisinger's parent company. Its 14-member external governing board oversees the collective efforts of the nine Geisinger-affiliated entities and their activities in health care and related businesses. The Foundation is involved in the activities of raising and distributing funds for health care and related purposes.

GEISINGER CLINIC

The Geisinger Clinic, a not-for-profit corporation, employs all 357 physicians in the system. 229 are on the staff of the Geisinger Medical Center in Danville, 30 are members of Geisinger Medical Group - Wilkes-Barre. 98 practice at 33 additional Geisinger sites throughout the region.

Because the group practice is the driving force of the Geisinger system, Geisinger has had physician leadership throughout its history. To prepare physicians for leadership, a management course for physicians, the Physician Management Education Program (PMEP), was initiated in 1985 in collaboration with the Sigmund Weis School of Business at Susquehanna University.

Modeled after graduate programs in business administration, the program is tailored to the specific needs of the physician-as-manager. The faculty includes nationally recognized instructors from established schools of health care administration.

The Clinic administers the research program. Geisinger physicians have engaged in clinical research from the beginning. Since reaffirming the commitment to research in 1980 and a need to expand the program, the number of clinical research projects has tripled and funding has grown to $1.5 million annually. Much of this research constitutes participation in national cooperative programs, primarily related to cancer and cardiovascular disease.

In September 1985, ground was broken for a new research center for a core program in basic cardiovascular research. In December 1985, the building was named the Sigfried and Janet Weis Center for Research, in honor of the Geisinger Foundation chairman and his wife. This center

for research opened in May, 1987. Ten laboratories are in operation and space exists for an additional ten to be completed later. Dr. Howard E. Morgan heads the team of ten full-time scientists.

GEISINGER MEDICAL CENTER

The Geisinger Medical Center, a not-for-profit corporation, owns and operates a 569-bed regional referral center in Danville, Pennsylvania, which is the flagship of the system. The medical center has regional centers for cancer, kidney disease, heart, neurosciences, trauma and a Children's Hospital Center. It operates the Life Flight helicopter retrieval program, which has served over 100 hospitals in six states while transporting more than 870 patients a year. Specialty services dedicated in 1985 include magnetic resonance imaging and a six-patient hyperbaric medicine chamber. A lithotripter was installed in 1986.

In October 1986, Geisinger Medical Center was designated a Regional Resource Trauma Center based on the provision of comprehensive trauma care 24 hours a day and the conduct of outreach, educational and research programs in trauma care.

At Geisinger Medical Center 188 physicians are training in 15 approved residency programs and five fellowship programs. Over 2,200 nurses have graduated from the Geisinger School of Nursing, which opened when the hospital was founded in 1915. In addition, there are nine allied schools of health.

Geisinger Clinic physicians provide the faculty for graduate and undergraduate medical education at Geisinger Medical Center, as well as programs for continuing medical education.

GEISINGER WYOMING VALLEY MEDICAL CENTER

The Geisinger Wyoming Valley Medical Center, a not-for-profit corporation, owns and operates a 230-bed open-staff community hospital in Wilkes-Barre, Pennsylvania, which opened as the NPW Medical Center of N.E. Penna. Inc. in 1981. Serving the Greater Wyoming Valley and western Pocono region, Geisinger Wyoming Valley Medical Center offers comprehensive maternity and pediatric programs, five medical/surgical units and a complete emergency department.

MARWORTH

Marworth, a not-for-profit corporation, owns and operates two centers for the treatment of alcohol and chemical dependency. A 72-bed treatment detoxification and rehabilitation center near Scranton, Pennsylvania opened in 1982, and has gained national recognition. In October, 1986, Marworth opened a 56-bed adolescent chemical dependency treatment center at Shawnee on Delaware.

Both programs address the physical, social and psychological issues of treatment and recovery. Marworth's family treatment program is an important part of these centers.

GEISINGER HEALTH PLAN

The Geisinger Health Plan, a not-for-profit corporation, operates a health maintenance organization. The Geisinger Health Plan was reorganized and incorporated in 1984 and licensed for marketing in 17 counties. The Geisinger Health Plan has over 55,000 members enrolled.

Health care services are provided primarily by Geisinger physicians distributed throughout the physician network developed since 1981 by the Geisinger Clinic and Geisinger-owned hospitals. Independent physicians and community hospitals in several communities are also participating.

GEISINGER MEDICAL MANAGEMENT CORPORATION

The Geisinger Medical Management Corporation is a wholly-owned, for-profit corporation of the Geisinger Foundation that provides consultative and contract management services. As the development arm of the system, it developed Geisinger Wyoming Valley Medical Center and Marworth. In addition, Geisinger Medical Management Corporation offers management, consulting and other medical services to health care providers outside the Geisinger system.

INTERNATIONAL SHARED SERVICES, INC. (ISS)

Acquired in 1984, ISS is a for-profit corporation which provides biotechnology maintenance and repair service to 150 hospitals and physician offices in Pennsylvania, six adjacent states and the District of Columbia.

GEISINGER SYSTEM SERVICES

Geisinger System Services (GSS), a not-for-profit corporation, provides management and consultative services to other Geisinger entities. GSS prepares, implements and audits policies and procedures of system-wide relevance and implements uniform standards and methods of management throughout the system.

Services provided by GSS to other entities within the system include communication and public affairs, facilities management, financial management, human resources, internal audits, legal services, management engineering, management information systems, marketing services and materiels management.

DEPUY-LENAPE CORPORATION

DePuy-Lenape Corporation is a for-profit corporation formed in 1985 as a joint venture between the Geisinger Foundation and Shawnee Development, Inc. to establish a primary health care center in Shawnee on Delaware. This primary care center opened in September 1986.

Statement of

THE HOSPITAL ASSOCIATION OF PENNSYLVANIA

on Senate Bill 1765

to be Entered in the Record

of the Senate Committee on Finance

November 24, 1987

The Hospital Association of Pennsylvania represents 265 acute care and specialty hospitals in the Commonwealth. Pennsylvania's hospitals appreciate this opportunity to submit for the record our comments on the nursing shortage and on Senate Bill 1765.

Within the organizational structure of The Hospital Association of Pennsylvania is a Council of Hospital-Based Schools of Nursing, representing 42 diploma schools of nursing, and the Pennsylvania Organization of Nurse Executives, comprising nearly 400 nurse executives of health care institutions across the state. Thus, the Association is very involved in nursing issues.

During 1987, we conducted a comprehensive Statewide Nursing Study to delineate issues regarding nursing education, nurse supply and demand, and attitudes of licensed nurses in the Commonwealth and to provide a framework for future efforts directed at solving the nursing shortage.

Pennsylvania is the nation's third-largest educator and provider of professional nurses, many of whom choose to work in other states. In 1986, 4,869 nurses were prepared by professional schools of nursing in Pennsylvania; in the same year, 4,946 were endorsed to work outside of Pennsylvania and only 2,760 were endorsed into Pennsylvania from other states. The Pennsylvania Department of Labor and Industry says that our state creates a demand for 6,017 new RNs each year. It is clear that Pennsylvania is no longer able to prepare the number of RNs needed in the state, not to mention those who choose to go elsewhere.

The Statewide Nursing Study clearly documents the problem of persistent declining enrollments in all nursing education programs in the

Commonwealth. With a declining pool of graduating secondary school students and expanded educational opportunities available, particularly to women, enrollment of students in nursing schools has become increasingly difficult.

Although there have been significant increases in representation of females in predominantly male professions, there have not been similar increases in the representation of males in predominantly female professions, such as nursing. Perhaps the main thrust of the federal government should be in support of programs which will enhance the image of nursing. The public needs to be bombarded with audio and visual concepts which depict nurses as highly skilled, well educated, and competent professionals.

The Association's Statewide Nursing Study also documented the fact that many specialty areas in nursing are experiencing critical and consistent shortages.

In some regions of the state, the average age of an operating room [n]urse is 43 years. There is evidence that nursing education today does [not] prepare the type of practitioner needed to meet the surgical [req]uirements of the industry.

With advanced health care technology and increased life expectancy, [o]ur hospitals are admitting increasing numbers of acutely ill patients. Critical care nurses, as well as those who function in the medical-surgical specialties, are experiencing some of the highest vacancy rates. The acuity level of patients today requires essentially one nurse per patient. Even though there are more nurses working nationwide than ever before, critical shortages exist because of excessive demand which is not expected to abate in the near future. Rather, federal government projections indicate a shortfall of 600,000 nurses by the year 2000.

A much broader educational base must be sought to support those health care institutions which are financially assuming the burden of educating beginning practitioners who deliver the bulk of care to the public. Unfortunately, the funding proposed in S. 1765 will benefit only a small number of the nursing population. It should be noted that of the two million nurses in this country, 65 percent are prepared and practicing at

less than the baccalaureate level and thus are not eligible to enter postgraduate programs. Basic nursing education programs also need funds to provide bedside nurses who deliver care to the masses. This same group of nurses must receive financial encouragement to seek additional education.

Although geriatric nurse practitioners are needed to meet the needs of our rapidly aging population, this clinical training program cannot be isolated simply at the postgraduate nurse level for relatively few nurses will benefit from such an approach. The problem of geriatric care is much broader than simply community care settings.

With the Medicare prospective payment reimbursement system under which hospitals operate, it is increasingly difficult for acute care hospitals to provide the necessary education for nurses to meet the deficiencies in the educational process that exist. Compounding this problem is the need to increase salaries of the professional nurse. Without increased financial reimbursement for hospitals, there is a point beyond which it no longer is feasible to raise salaries and remain financially healthy. The government should consider expediting as well as increasing reimbursement.

Salaries are a key factor in an institution's ability to recruit and retain competent professional nurses. The large vacancy rates in middle management signal attrition at the staff level with an inability to make management positions attractive enough. Attrition costs are staggering and orientation expenses present an overwhelming dilemma for health care institutions. The current reimbursement methodology simply does not allow hospitals to recruit and retain the number of qualified professionals needed.

Although seven demonstration projects are proposed in this act, they are designed to be hospital-based postgraduate clinical nursing programs requiring hospital-college affiliations. Because of their location, rural hospitals will not be afforded the opportunity for such affiliations.

We believe S. 1765 would benefit only a small segment of Pennsylvania's aging population because hospitals without community-based nursing programs would be ineligible for funds. Under the act, an "eligible organization" would be "a public or private entity, organized

under the laws of the state, which is primarily engaged in the direct provision of community nursing and ambulatory care" or "the entity provides directly, or through arrangements with other qualified personnel, community nursing and ambulatory care."

We know that the population over 65 is growing two-and-one-half times faster than the population under age 65 and there is a projected population of 60 million Americans over age 65 by the year 2020. The elderly currently use 40 percent of the nation's hospital and physician care. Pennsylvania is one of the nation's leaders in providing care to the elderly. Last May, the American Association of Retired Persons opened its first state office in our capital city because of our large elderly population. It has to be remembered that the community health setting is only one small segment of the health care delivery system for these citizens.

The title of the bill suggests it is intended to alleviate the shortage in nursing manpower. But this intent is questionable, given the narrow scope of the nursing shortage addressed.

Since the bill does not address Medicare and Medicaid reimbursement for nursing services provided by certified, registered nurse practitioners or clinical nurse specialists, the tone of the text seems to suggest a beginning for a two-tiered system of health care delivery for our nation. In Pennsylvania, the indigent care burden is great, but we do not think nursing care should be seen as the ultimate cost-effective solution to this comprehensive problem.

There is no easy solution to the nursing shortage. However, funding for nursing education at the entry level and enhanced reimbursement for providers would likely do more than any other measure outlined to date. The data compiled in Pennsylvania's Statewide Nursing Study defines these economic implications. With too few dollars chasing too few nurses, the demand continues to escalate. The problem will continue to exacerbate until the core of nursing image, education, and compensation are financially enhanced. The future of our quality health care system is rooted in nursing.

THE NURSING SHORTAGE: DISCUSSION AND RECOMMENDA TIONS

Donalda Dunnett RN
Gary Peichoto RN, M.S.

Staff Nurses in Cardiovascular Intensive Care

Stanford University Hospital
300 Pasteur Dr.
Palo Alto, CA 94305

By now, everyone is aware that there is a crisis in nursing. Nurses are leaving the profession in significant numbers and nursing is suffering from decreasing enrollments in nursing programs. The end result is that the remaining nurses are having to look after more patients who are considerably sicker than they were 10 years ago. This last factor is due to increasing technological and medical advancements. Computerized equipment, improved pharmacological agents and increased scientific knowledge can now combat disease processes to produce a longer life with a better quality of living. However, society is now faced with fewer nurses to provide this advanced health care which in turn affects the quality of that care.

With health care technology constantly changing, advancing, growing, all health care workers are continually updating their knowledge base. There are so many more responsibilities now, that decreasing the nurse-patient ratio is necessary to provide the optimal quality care. However, the nurse-patient ratio is increasing due to the nursing shortage!

Obviously nursing is a female dominated profession and traditionally an accepted profession. Today there are many other career opportunities available to women and nursing is becoming a much less attractive option. There are several other factors which make nursing a second best choice.

Nursing salaries generally average out to $25,000/year and the bedside nurse attains maximum salary range at 5 years. Fom this point, most opportunities for advancement are away from the bedside into administration. Middle management such as assistant head nurse and head nurse make very little more than the staff nurse.

Another factor that leads young people and seasoned nurses away from nursing are the working conditions. Shift work, weekend and holiday staffing are necessary and a bedside nurse will <u>always</u> have to work these off hours. Also, the increased nurse-patient ratios and high patient acuity means that the nurse has to contend with the frustration of being unable to give the quality care needed to produce satisfaction in a job well done. In fact, the nurse can often, at best, only

hope to keep the patients alive until the end of shift. The shortage of nurses means more people working overtime to cover minus staffing. The fluctuating acuity of the patients also means nurses will be doing overtime to cover crisis situations. Stanford University Hospital has better staffing than most hospitals. Nevertheless, the overtime hours in the Cardiovascular Intensive Care average above 200 hours every 2 weeks.

We would like to suggest some positive ways by which the profession as well as government might improve nursing. The public image of nursing must change before we will be able to drastically affect the declining enrollments in nursing schools. There are many talk shows and news segments about the nursing shortage. Now that we have the public's attention, we need to change some perceptions. One place to start would be to try and reqrient society into not thinking of it as a respectable white woman's career but as an attractive career for both sexes as well as minorities. Nursing educators, professional organizations and government health agencies need to produce videos, brochures and other informational aides in order to reach all primary education levels, especially junior high and high school students. Funding for educational grants for this purpose would be helpful.

Hand in hand with this effort is the need to ed ucate and inform the public about AIDS. Patients, their families and other members of the public often ask nurses, "Aren't you afraid of catching AIDS ?". It is obvious by talking to high school students that the fear of diease, specifically AIDS, is a factor against nursing as a career choice. If the current public hysteria towards AIDS continues, it may significantly affect the number of potential nurses. Our future nurses come from the youth of the nation so we need to begin serious educational efforts in our public schools: people must understand that AIDS is difficult to catch and that there are effective safety precautions.

Despite the fact that nursing is perceived as a high cost in total health care expenditures, in actuality nursing costs are a minor part of a patient's total hospital bill. In a study done at Stanford University Hospital in 1983 the direct nursing care costs of a patient's bill averaged out to 8%. (Please see article attached "Determining Cost of Direct Nursing Care by DRGs" Malinda Mitchell, RN. M.S.) Therefore, even though the federal deficit caus es grave concern, one direct action that Congress can take is to increase the salaries of the nurses in the Federal system. With the Federal nursing systemserving as a nursing model across

the nation, it would become newsworthy. This i s one way to attract attention to the nursing profession as a valuable asset.

Hospitals, public and private, can foster supportive working environments for recruitment and retention of nurses. Stanford offers several attractive benefits.
(1) Sick leave and vacation time are combined into one bank called Paid Time Off or PTO. Nurses may use this time as needed when they are sick or allow it to accrue. It encourages work while not punishing the employee who does not get sick. Nurses have been able to take up to 2 years off for various needs.
(2) Nurses may work part time from half time to 4 days a week with benefits which often makes it easier for students or young mothers to plan their lives. Nursing is a stressful environment and, having the flexibility to drop time commitments, alleviates burnout.
(3) Stanford has a clinical ladder series which rewards clinical expertise with a higher salary step. It recognizes the nurse who does more for the patient and the hospital.
(4) There are several joint committees between nursing management and the staff such as the Stanford Nursing Practice Committee, and between physicians, nurses and other services such as the Ethics Committee, which allows the staff nurse input into the actual practice of the hospital and promotes a feeling of self worth and loyalty to the hospital.

All these recommendations need government encouragement, of which one aspect is money. More nurses need to be encouraged to stay in the profession and young people need to be recruited, otherwise health care will rapidly deteriorate. Someone has to be there and that someone must know what to do in this high-tech world: patients recognize that someone as "their nurse".

Determining Cost of Direct Nursing Care by DRGs

Are DRGs sensitive enough to their case's range of resource use?

by Malinda Mitchell, Joyce Miller, Lois Welches & Duane D. Walker

Hospitals across the United States are trying to determine costs for the DRGs of their patient populations as the prospective reimbursement system tightens its grip upon the incomes they can expect in the 80's. This task will be the more difficult for many hospitals because charges, not cost, have been their accustomed basis for budgeting. Formerly, there was almost no incentive to assess financial status in relation to individual diagnoses. Now, departments must begin to produce more specific cost data so that careful analysis of cost per DRG can begin. Nursing Administrators are finding themselves challenged to determine cost of nursing care per DRG, as well as the variation of cost within and between DRGs.

To do this, Nursing Departments must be able to specify resources used for each individual patient. The Departments must also be able to record and determine total resources used throughout an entire admission and then be able to calculate the cost of resources used. Patient classification systems offer means for assembling and expressing pertinent data to develop these capacities. Indeed, their very purpose is determining the resources each patient should be assigned according to the intensity of service which his assessed condition demands.

Pilot study

At Stanford University Hospital the Department of Nursing conducted a pilot study to begin assembling some of the needed information regarding costs related to DRGs. The study's purposes were:

(1) To determine the average hours and costs of direct Nursing care for DRGs through the use of a patient classification system;

(2) To determine the range of hours and cost of direct nursing care used within DRGs;

(3) To determine the relationship between total hospital charges and the cost of direct nursing care.

The pilot study took place from March to August, 1983. Researchers initially selected six admitting diagnoses for the study. Sufficient data to report the findings has been collected on three of them: myocardial infarction, total hip replacement, and fractured hip. In the four Nursing Units which agreed to participate in the study, patients admitted with the selected diagnoses were included in the study population. During these patients' entire admission, their hours of nursing care were determined each shift according to the Nursing Department patient classification system.

Patient classification system

Some form of time-based patient classification system has been in existence at Stanford for eight years. A major revision and partial computerization took place two years ago. This classification system, designed to determine the hours of nursing care needed by each patient each shift, indicates all components of the Nursing Process. Assessment, evaluation and implementation are present as specific indicators. (See Exhibit I.) A "unit constant" indicator includes care planning, charting, report and other activities of the care givers. Each shift, nurses taking care of the patients check indicators on a form which represent the nursing care the patient needs. Each indicator or activity has minutes associated with it. The times associated with the activities are based on time studies from many hospitals which have been pooled to form a large data base. These patient classification forms are put through a computer scanner which calculates the hours/minutes of nursing care required by

MALINDA MITCHELL, MS, RN, JOYCE MILLER, MN, RN, and LOIS WELCHES, DNSc, RN, are Associate Directors of Nursing, and DUANE D. WALKER, MS, RN, FAAN, is Director of Nursing, Associate Hospital Director, at Stanford University Medical Center Hospital, Stanford, California, where this study was undertaken in Summer, 1983.

EXHIBIT I

STANFORD UNIVERSITY HOSPITAL: PATIENT CLASSIFICATION MEDICAL/SURGICAL UNITS

10 1	2	3	4	5	MONTH:	UNIT:	10 1	20 2	30 3	40 4
10 1	20 2	30 3	4	5	DAY:	SHIFT: PAGE:	1 1	2 2	3	4
	1 2 3	1 2 3	1 2 3	1 2 3	PATIENT AGE CODE		1 2 3	1 2 3	1 2 3	1 2 3
	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	PATIENT SERVICE CODE		1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
					PATIENT NAME					
	[illegible]	[illegible]	[illegible]	[illegible]	ROOM NUMBER		[illegible]	[illegible]	[illegible]	[illegible]
	1	1	1	1	1. Unit Constant		1	1	1	1
	2	2	2	2	2. Isolation		2	2	2	2
	3	3	3	3	3. Bath-Total		3	3	3	3
	4	4	4	4	4. Bath-Partial		4	4	4	4
	5	5	5	5	5. Feed-Total		5	5	5	5
	6	6	6	6	6. Feed-Partial		6	6	6	6
	7	7	7	7	7. Immobility-Major		7	7	7	7
	8	8	8	8	8. Immobility-Moderate		8	8	8	8
	9	9	9	9	9. Immobility-Minor		9	9	9	9
	10	10	10	10	10. Assessment Q 30 Min.		10	10	10	10
	11	11	11	11	11. Assessment Q 1-2 Hrs.		11	11	11	11
	12	12	12	12	12. Intervention Q 30 Min.		12	12	12	12
	13	13	13	13	13. Intervention Q 1-2 Hrs.		13	13	13	13
	14	14	14	14	14. Intervention Q 4 Hrs.		14	14	14	14
	15	15	15	15	15. Frequent Linen Change		15	15	15	15
	16	16	16	16	16. Specimens		16	16	16	16
	17	17	17	17	17. I & O		17	17	17	17
	18	18	18	18	18. Pre Op Activities		18	18	18	18
	19	19	19	19	19. Monitored (Electronic		19	19	19	19
	20	20	20	20	20. LINA		20	20	20	20
					OPTIONAL DATA					

each patient each shift and converts this data into the number of nurses needed on the nursing unit.

Methodology

During the study, the Clinical Nursing Coordinator or her Assistant recorded the hours of care which the patient classification system indicated. These hours were taken directly from the patient classification computer printout. When the patient was discharged, the records were collected from the nursing unit and totalled for hours of care on a 24-hour and on an entire admission basis.

The total hours of nursing care for the admission were translated into costs in the following way. The hours of care given were multiplied by the average hourly salary and benefits for direct care givers on the respective units. This took into account the ratio of RN to NA. The correct percentage of each care giver on the unit was used to determine the average salary for the unit. Thus:

Direct Hours of Care		Average Salary and Benefits for Direct Care		Cost of Direct Nursing Care
	x		=	

After discharge the patients were grouped into appropriate DRG categories and its DRG number assigned.

Data was initially collected on 118 patients. From that group, 89 fell into the following four DRG categories.

DRG		n
121	Acute MI W/Comp.	13
122	Acute MI W/O Comp.	12
209	Major Joint Procedure (Total Hip)	32
210	Hip and Femur Procedures Except Major Joint, Ages 65 or with Complications (Fx Hip)	32

Findings

The direct nursing care resources used in the four DRGs were determined by using patient classification system data. The average hours of care per DRG are shown below:

DRG		Average Hours of Care
121	(MI W/Comp.)	109
122	(MI W/O Comp.)	68
209	(Total Hip)	88
210	(Fx Hip)	95

As the hours of care were collected, daily averages were calculated for the DRG group. The following graphs show profiles of the average hours of direct nursing care for each day of admission for these DRGs. (See Exhibits II, III, IV and V.)

Their interesting patterns demonstrate that the nursing resource use for the different DRGs varies considerably. The amount of care given to the MI patient as opposed to that given a fractured hip patient distributes very differently over the course of the admission. This variation will be important to consider when analyzing methods for cost reduction, especially reductions in length of stay.

As more data is collected, more comparisons can be made of the profiles of different DRGs. Standards or norms for hours of care and their distribution may evolve from such comparisons.

The second step in the pilot study converted the nursing hours of care to costs. According to the formula established, hours of care were multiplied by hourly salaries and benefits. This yielded the following:

DRG	Average Hours	Average Cost
121	109	$1,778
122	68	$1,109
209	88	$1,368
210	95	$1,476

Of course, these figures only represent the cost of direct care givers — the variable portion of the nursing cost. To calculate total nursing costs one must add the costs of Nursing Administration, Unit Management, overhead (indirects) and Nursing Education. These invariable, fixed costs can be calculated on a patient-day basis and added to the cost for each day the patient is in the hospital. They will not necessarily vary by patient diagnosis or intensity.

Next, the study determined the range of resources (hours of care) used within each DRG. The DRG system is said to be based on "like" resource usage. Supposedly, each DRG is grouped so that the resource use within each DRG is similar. This does not seem to be true because severity of illness has not been taken into account. Within each DRG, patients may fall anywhere in the continuum from slightly to severely ill.

The ranges of hours of care for the four DRGs are shown in the following table. Obviously, the range of hours for all of them is great, and, with the possible exception of DRG 122, the standard deviation (s.d.) is very large as well.

DRG	n	Range Hours	Mean	s.d.
121	13	61-237	109	+9.6
122	12	+8-90	68	11.5
209	32	33-168	88	29.1
210	32	+2-206	95	+5

When the hours are converted to costs, the range becomes even more dramatic:

DRG	n	Range of Costs
121	13	$828-3,218
122	12	$652-1,222
209	32	$427-2,174
210	32	$543-2,666

This wide range and large s.d. indicate that "like" nursing resources are not used within all of the four DRGs studied. The range is probably even greater for some DRGs than is evident in this pilot study. Only one diagnosis was studied within each DRG. For DRG 209 (Major Joint Procedures) and 400 (Hip and Femur Procedures), there are many other diagnoses that could fall into each DRG category. The greater the variety in diagnoses within given DRGs, the greater the possibility of a wider range in resource use.

The Severity of Illness Index was completed for each patient in the study and appears to be a way to reflect more accurately "like" resource usage. Once patients have been separated into severity of illness groups, the range of resource usage within each severity group is much smaller. This will be analyzed further as the study sample increases.

Finally, the study analyzed the relationship of total charges to direct nursing care costs within one DRG. DRG 209, Total Hip Replacement, was selected for this purpose. The average hospital bill for the 32 patients in DRG 209 was $10,864.00. The range was $9,798.00 to $28,703.00. The average direct nursing care costs were $1,368.00. Therefore, the average direct nursing care costs were eight percent of the average hospital charges.

	Hospital Charges	Direct Nursing Care Costs	%
Mean	$10,864.00	$1,368.00	8%
Low Range	$ 9,798.00	$ 427.00	4%
High Range	$28,703.00	$2,174.00	8%

In the future, it will be more important to compare the direct and total nursing care costs with total hospital costs rather than to compare them with general charges for a hospitalization. At this moment, true costs for many departments have not been sufficiently determined for such specific cost comparisons to take place.

Into the future

The study has convinced us that a time-based patient classification system can be used to determine nursing resource usage. Further study with larger patient populations and more diagnostic groups will follow this pilot study. Indeed, the methodology for determining direct nursing costs will be extended to all patients as soon as the patient classification system has been completely computerized. The present system will be modified so that hours of care for each patient will automatically be collected and totalled on a 24-hour basis and for the total admission. Determining this information for large groups of patients in a variety of settings is essential.

The range of resource usage by DRG will continue to be analyzed in conjunction with the Severity of Illness Index ratings. With the severity of the patient taken in account, we expect smaller variations in hours of direct nursing care than those currently seen with the existing system.

The costs of direct nursing care continue to be compared to total charges and charges from ancillary departments. As soon as accurate costing has been accomplished for other departments, the nursing care costs can be compared with other *costs* rather than *charges*. □

EXHIBIT II
MYOCARDIAL INFARCTION DRG 121

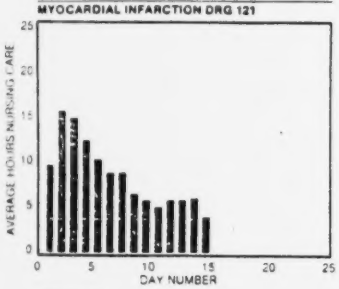


EXHIBIT III
MYOCARDIAL INFARCTION DRG 122

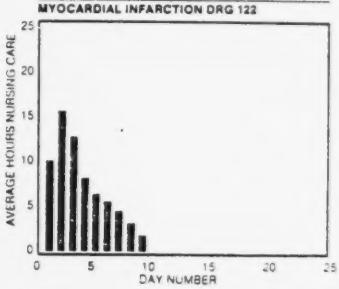


EXHIBIT IV
TOTAL HIPS PATIENTS DRG 209

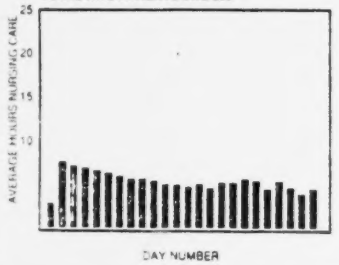
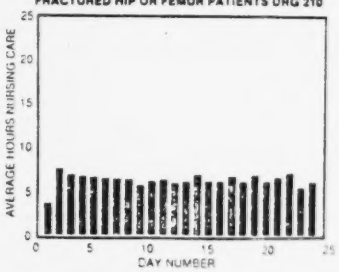


EXHIBIT V
FRACTURED HIP OR FEMUR PATIENTS DRG 210



November 3, 1987

Senator George Mitchell
Chairman-Senate Finance Subcommittee
on Health
Washington, DC 20510

Sir:

In relationship to the Nursing Manpower Shortage Act of 1987: The nursing shortage crisis will affect many elderly needing nursing services, whether in hospital, nursing home, skilled care facility, or home simply by a lack of numbers. However, to compound the problem, there is a lack of understanding on the part of "representatives" of the people that the real shortage is one of qualified and educated nurses. I was appalled to hear from Representative Stark (D-CA) when I was in Washington two weeks ago that he felt four year educated nurses were not necessary to take care of our elderly in nursing and skilled care homes. TELL THE ELDERLY THAT! He suggested that we could take any one out of high school and give them a little training and put them in hospitals and nursing home to care for the sick and elderly. He fails to understand:

the elderly have more complex health problems thus require assessment skills far beyond what could be taught in a short course to untrained individuals,

the elderly have psychosocial needs that the less mature, undereducated "trained" individual would neither understand nor be able to deal with,

care of the elderly is not one of maintenance, as suggested by Rep. Stark, but rather one of assisting the individual to regain, maintain, and strengthen his/her independent living skills or potential,

that by the year 2000 the elderly will determine health care policy and therefore, politically it is prudent to understand their needs now or very shortly these elderly will put someone into congress who does understand their needs.

It is imperative that any Nursing Shortage Act address the health care nursing service needs of RURAL AMERICA and that included in this bill is emphasis on education and quality as well as quantity of the nurses required to meet these rural health care needs.

Sincerely,

A. Yvonne Gorecki, RN, MPH, MA
Administrative Director, Patient Care Services
St. Joseph's Hospital & Health Center
Dickinson, ND 58601 (701.225.7205)

UNIVERSITY of PENNSYLVANIA

School of Nursing
Nursing Education Building
Philadelphia, PA 19104-6096
Claire M. Fagin, Ph.D., R.N.
Dean and Professor

November 9, 1987

Senator George Mitchell
Chairman
Senate Finance Subcommittee
on Health
Hart Senate Office Building
Washington, DC 20510

Dear Sen. Mitchell:

I am very much in support of your work on examining the nursing shortage crisis. I strongly endorse Medicare coverage for the services of certified nurse midwives and and also demonstration projects in underserved areas of prepaid community nursing systems.

A major problem which must be addressed is the drastic decline in interest in nursing as a career and the adverse consequences this suggests to access and quality of health care in the future. As needs of patients become more complex it is essential to recruit and retain talented, well educated and career oriented professional nurses. Development of more attractive conditions of professional practice in hospitals is basic to solving both entry problems in nursing and maintenance of nurses in the profession. Changes in certain conditions are absolutely essential. These include:

- Economic rewards

o differentiated salary structure that rewards advanced education and experience

o use of wage and other incentives to fill unpopular hours and eliminate the requirement for shift and weekend rotation
o more creative use of fringe benefits to reward longevity

o nursing career ladders to keep nurses in patient care

o restructuring the work of nurses and other personnel to result in more cost effective use of nurses in patient care. This might result in fewer and better paid nurses and more non-clinical support personnel who are in greater supply.

o examination and redefinition of titles used to describe nursing roles and levels of practice

o opportunity for nurses to influence policies of hospitals, including nursing activities. This would involve having nurses on boards of trustees, as members of executive committees of medical staff and hospital and other policy making and planning bodies

I am enclosing a recent article of mine and have marked the areas dealing with the nursing shortage. I hope that this will also be helpful. Many thanks for your support.

Sincerely,

Claire M. Fagin
Dean and Professor

VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37240 TELEPHONE (615) 322-7311

School of Nursing • Direct phone 322-4400

November 18, 1987

The Honorable Senator George Mitchell,
Chairman, Senate Finance Subcommittee on Health
Room 176
Russell Senate Office Building
Washington, DC 20510

Dear Senator Mitchell:

As the Dean of the School of Nursing at Vanderbilt University in Nashville, Tennessee, I want to express my concern to the Senate Finance Subcommittee on Health that a major portion of the long-term solution to the nursing shortage can be found in the establishment of education grants for nurses and non-nurses to attend school.

One source of these funds for nursing students would be to create equity in the Graduate Medical Education funds so that Medicare would fund graduate nursing students at levels consistent with their funding of Medical students.

While I know that financing the education of nurses is not the primary focus of the Senate Finance Subcommittee on Health, it is the pivotal issue in addressing the nursing shortage, which can touch each and every one of us as we need nursing care.

An additional problem is that the new congressional method of determining a student's need means that more and more older independent students will become eligible for less and less assistance. The numbers of dependents which an independent student may need to support are no longer included in the estimate of need. Need is now calculated based on the student's prior year's earnings as opposed to the estimated earnings of a person who is going to school while working part-time.

These penalties for being an independent student are not in any way offset by the new definitions of "Displaced Homemakers" or "Displaced Worker". To be considered a "displaced homemaker" a student would need to have been out of the job market for a minimum of 5 years prior to the loss of support. A "displaced worker" would need to have lost a job due to decline in economic conditions.

These are not conditions that are typical of potential nursing students.

Currently, the average age of our students at Vanderbilt University School of Nursing is 34-35 years old. Our students are predominantly female with minor children.

Recent conversations with the National Student Nurses Association revealed there is a nationwide trend toward older students enrolling in nursing programs.

It seems unfortunate that, during a time when nurses are in such short supply, there would be a decrease in the availability of student aid for higher education. While the impact of the changes in the definition of need will not be as adverse for the traditional young college student, it may prove devastating for Schools of Nursing which are attracting older students. National League of Nursing enrollment statistics, released earlier this year, clearly reflect the aging of the nursing student body and a radical increase in part-time student enrollments. The move toward part-time study directly reflects the already insufficient level of student aid.

Our experience at Vanderbilt University School of Nursing is that there is broad interest in nursing as a career goal. What is not available are adequate (or even minimal) sources for student aid. Our students are now mostly part-time, and carry 1/3 of a normal full-time semester course load. This will only serve to slow their entry into practice where they are so desperately needed. Our program is full; we have a waiting list to enroll; and we have received more than 1/,000 inquiries since September of 1986.

I would implore this Commission to carefully include a system of adequate financial aid for nursing students in any solutions it proposes to the nursing shortage.

Thank you for your consideration.

Sincerely,

Colleen Conway-Welch

Colleen Conway-Welch, PhD, CNM, FAAN
Professor and Dean, School of Nursing

CCW/sc

83-151 (140)